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ABSTRACT

This document comprises a collection of conference papers that provide a broad understanding of the problem of homelessness, highlight innovative local and state responses, and uncover key intergovernmental issues that must be addressed in order to improve public and private action. The conference was attended by more than 100 federal, state, and local officials, as well as by academic experts, advocates, and service providers. The document begins with "Opening Remarks: The Interagency Council on the Homeless" (C. Moore), which describes the federal agency whose primary function is to implement the Stewart B. McKinney Homeless Assistance Act of 1987. Part I, "Defining the Dimensions of Homelessness," comprises the following papers: (1) "Homeless Policy: Expansion during Retrenchment" (D. W. Kirchheimer); (2) "Discussion Paper: Implications of the Low-Income Housing Ratio for National Homelessness Policy" (K. Y. McChesnesy); (3) "The Deinstitutionalization of the Mentally Ill" (H. R. Lamb); (4) "The Low-Income Housing Crisis and Its Impact on Homelessness" (C. N. Dolbeare); and (5) "Rethinking Housing with the Homeless in Mind" (J. Leavitt). Part II, "Exploring Intergovernmental Responses," comprises the following papers: (1) "Hope for the Homeless--Local and State Responses" (K. J. Beirne); (2) "Homelessness: Federal and State Legislative Solutions" (M. Foscarinis); (3) "Ohio's Coordinated Responses to the Problems of Homelessness" (D. Roth and P. S. Hyde); (4) "Discussion Paper: The Ohio Case" (N. G. Milburn); (5) "Assisting the Homeless in an Era of Federal Retrenchment: The Massachusetts Experience" (N. K. Kaufman); (6) "State Coordination of Mental Health Services to Homeless People in Massachusetts" (C. B. Johnson); (7) "Milwaukee"s Outreach to the Homeless Mentally Ill" (M. Rosnow); (8) "Homelessness and the New Federalism: The Westchester Experience" (A. P. O'Rourke); and (9) "Health Care for the Homeless: The Challenge to States and Local Communities" (J. D. Wright). Some papers include statistical data on tables and graphs. All papers include a list of references. A description of the Advisory Commission on Intergovernmental Relations (ACIR) and a list of its publications are included. A copy of the conference program and lists of participants and attendees are appended. (FMW)

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Assisting the Homeless: State and Local Responses in an Era of Limited Resources

Papers from a Policy Conference
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Assisting the Homeless: State and Local Responses in an Era of Limited Resources

Papers from a Policy Conference
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Preface and Acknowledgements

The problem of homelessness in the United States has burst on the public scene so forcefully in the last few years that the issue has been seen by many citizens as almost overwhelming. Indeed, in some communities, the private organizations which traditionally have responded to homeless people have been overloaded with requests for assistance. Consequently, the public sector, especially local and state governments, has become deeply involved in the quest for solutions. Although local governments experience the problem of homelessness most directly, both the causes of and solutions to the problem involve the state and federal governments. As a result, the Advisory Commission on Intergovernmental Relations undertook a study of homelessness, primarily to identify intergovernmental issues so as to help improve public responses to this problem.

As a major part of this effort, the Commission hosted a national conference on "Assisting the Homeless: State and Local Responses in an Era of Limited Resources." The conference, held on March 10-11, 1988, in Washington, DC, was intended to develop a broad understanding of the problem, highlight innovative local and state responses, and uncover key intergovernmental issues that must be addressed in order to improve public and private action. The conference was attended by more than 100 federal, state, and local officials, as well as by academic experts, advocates, and service providers.

What complicates policymaking in this area is that homelessness is not a single uniform problem; rather, it is a series of separate and often interrelated problems reflecting the different needs and circumstances of diverse groups of homeless persons. These problems stem from equally diverse causes. We are

no longer talking about just a so-called "skid row" problem.

In general, the homeless population consists of about one-third families with children, one-third persons who suffer from some form of mental illness, and one-third persons who are addicted to alcohol and/or drugs. Within these broad categories are found individuals who are employed, unemployed or underemployed, heads of families who need workday child care services, veterans, parolees, migrant workers, victims of domestic violence, runaway children, and stranded travelers—just to name a few.

The needs of some of these individuals and families can be met solely by providing low-income housing. In a few cases, only a minimum level of assistance is needed to resolve a problem. For others, however, housing alone is not sufficient, and for still others, maintaining their own household is not practical. Combinations of temporary shelter, social services, physical and mental health programs, long-term housing, community development, and institutionalization are needed to make adequate responses to the many dimensions of homelessness. By virtue of this diversity, therefore, it is all the more important that we have good public-private interaction, interagency coordination, and intergovernmental cooperation.

The Stewart B. McKinney Homeless Assistance Act of 1987 (*McKinney Act*) has begun to focus the attention of the national government on this issue, in part through the Interagency Council on the Homeless, which coordinates existing federal programs and resources. The *McKinney Act* has been reauthorized by the Congress for another two years with added resources to assist state and local governments in coping with the homeless population. In the main, however, it has been state and local governments which have provided leadership and initiative in responding to homelessness.

The papers presented in this volume attempt to define the diverse dimensions of homelessness and its causes, examine the problem of estimating the size of the homeless population problem (a difficult task, given the lack of adequate data), discuss innovative private and public responses, identify intergovernmental issues (such as state and local problems in coordinating the use of existing federal resources to help the homeless), and suggest additional local, state, and federal actions that might be initiated to meet the problems of the homeless more adequately.

Among the papers in this volume are those that describe how the states of Ohio and Massachusetts are orchestrating coordinated interagency responses to their multidimensional homelessness problems, how Milwaukee is reaching out to its mentally ill homeless persons, and how the multifaceted approach of Westchester County, New York, is responding to homelessness in an affluent setting. These examples of state and local action provide hope for the future.

The views expressed by the contributors to this volume are diverse and do not necessarily correspond with the views of the Advisory Commission on Intergovernmental Relations. The Commission encourages debate on intergovernmental issues and has sought to provide through this conference a forum for airing different viewpoints.

At its meeting on September 16, 1988, the Commission adopted a set of findings and recommendations that will be published in full in the December 1988 issue of the Commission's quarterly magazine, *Intergovernmental Perspective*. In brief, the recommendations call for:

- Public and private agencies to develop distinct but coordinated responses to homelessness capable of dealing with the diverse circumstances of homeless people;
- The federal government to reexamine—in consultation with state and local governments—its policies for low-income housing and support services, and its regulatory rules that may unnecessarily limit the flexibility that state and local governments need in order to utilize federal resources in assisting the homeless;
- The states to provide leadership in coordinating responses; allow local governments greater discretion to respond to local problems of homelessness; provide financial assistance to localities with high concentrations of homeless persons; and examine other policy areas that affect homelessness, such as deinstitutionalization of the mentally ill, drug abuse prevention, financial protection for divorced women with children, and residency requirements for school children;
- Local governments to encourage private responses to homelessness and develop creative ways to link private and public funding to help the homeless;
- Each community in a metropolitan area to contribute its fair share to assisting the homeless so as to ensure that no one community is unfairly burdened with the costs;
- Federal, state, and local governments and private organizations to develop systematic and reliable data on homelessness that facilitate public and private responses more precisely tuned to current conditions;
- Federal, state, and local governments to examine carefully their urban and suburban

development and redevelopment policies to ensure that they do not inadvertently result in a net loss of decent and affordable low-income housing; and

- State and local governments to examine policies that contribute to homelessness directly or indirectly, including zoning policies that inhibit low-income housing and income diversity within neighborhoods; building codes that unnecessarily increase the cost of decent housing for low-income people; rent control policies that discourage low-income housing development; property tax valuations that threaten low-income homeowners; residency requirements for school children; criteria for involuntary institutionalization; and procedures that make it almost impossible to locate facilities for the homeless in certain communities or neighborhoods.

As a follow-up to its own conference and research, the Advisory Commission on Intergovernmental Relations co-sponsored a conference on November 17-18, 1988, that was initiated by the Home Builders Institute and the National Association of Home Builders and was devoted to the theme "Builders Examine the Many Faces of Homelessness: Laying a Foundation for Action." The Commission's findings and recommendations were presented at the conference.

The Commission expresses its deep appreciation to Rosita M. Thomas, former ACIR analyst, for organizing the conference that formed the basis of this publication, and to the authors of the papers appearing in this volume for their excellent conference presentations and for their assistance in preparing the proceedings for publication. Appreciation is also due to the other designated discussants listed in Appendix I and to the participants listed in Appendix II for their contributions to the conference discussions and to our understanding of homelessness. Anita McPhaul of the ACIR staff provided valuable support assistance in administering the conference as well as many secretarial services. Finally, appreciation is expressed to Bruce D. McDowell and Joan Casey of the ACIR staff who edited the papers for publication, and to Lori O'Bier-Coffel for her typing assistance.

John Kincaid
Executive Director

Contents

Opening Remarks: The Interagency Council on the Homeless
Cassandra Moore, Executive Director, Interagency Council on the Homeless 1

Part I **Defining the Dimensions of Homelessness** 5

Homeless Policy: Expansion during Retrenchment
Donna Wilson Kirchheimer, Associate Professor of Political Science, Lehman College, City University of New York 7

Discussion Paper: Implications of the Low-Income Housing Ratio for National Homelessness Policy
Kay Young McChesnesy, Assistant Professor of Sociology, Indiana University of Pennsylvania ... 17

The Deinstitutionalization of the Mentally Ill
H. Richard Lamb, MD, Professor, University of Southern California 21

The Low-Income Housing Crisis and Its Impact on Homelessness
Cushing N. Dolbeare, Consultant on Housing and Public Policy, Washington, DC 31

Rethinking Housing with the Homeless in Mind
Jacqueline Leavitt, Associate Professor, Graduate School of Architecture and Urban Planning, University of California, Los Angeles 43

Part II **Exploring Intergovernmental Responses** 65

Hope for the Homeless—Local and State Response
Kenneth J. Beirne, Assistant Secretary for Policy Development and Research, U.S. Dpartment of Housing and Urban Development 67

Homelessness: Federal and State Legislative Solutions
Maria Foscarinis, Washington Counsel, National Coalition for the Homeless 77

Ohio's Coordinated Response to the Problems of Homelessness
Dee Roth and *Pamela S. Hyde*, Ohio Department of Mental Health 85

Discussion Paper: The Ohio Case
Norweeta G. Milburn, Senior Research Associate, Institute for Urban Affairs and Research, Howard University 95

Assisting the Homeless in an Era of Federal Retrenchment: The Massachusetts Experience
Nancy K. Kaufman, Assistant Secretary, Executive Office of Human Services, Commonwealth of Massachusetts 97

State Coordination of Mental Health Services to Homeless People in Massachusetts
Carol Bower Johnson, Director of Homeless Services, Massachusetts Department of Mental Health 105

Milwaukee's Outreach to the Homeless Mentally Ill
Mark Rosnow, Director of Research, The Planning Council for Health and Human Service, Milwaukee, Wisconsin 111

Homelessness and the New Federalism: The Westchester Experience
Andrew P. O'Rourke, County Executive, Westchester County, New York 121

Health Care for the Homeless: The Challenge to States and Local Communities
James D. Wright, Social and Demographic Research Institute, University of Massachusetts, Amherst 129

Appendices 141

The Conference 143

Participants 147

Attendees 149

Opening Remarks: The Interagency Council on the Homeless

Cassandra Moore
Executive Director,
Interagency Council on the Homeless

I am very pleased to open a conference devoted to a common goal, "Assisting the Homeless." Whether on a professional or personal level, we are all concerned with those in our midst who have no place to go, who stand on the corner or stand out in newspaper photographs. They can't go home again because there is no home. They have lost their moorings, and they drift.

Since the homeless began to become more visible, some seven or eight years ago, their presence has stimulated a variety of responses. Studies have pointed to the changing face of homelessness. No longer are the homeless mainly derelicts, old men who drink too much. Now, the homeless also are younger, often unemployed; now, a disturbing proportion are mentally ill; now, there are women and children and families. There are substance abusers and runaways. It's a heterogeneous group, and it poses a series of complex problems.

This conference will be discussing the innovative programs being developed by the public and private sectors, frequently working together, as they attempt to being help to those who need it most. I would like to outline for a moment the response of the federal government, in particular, the *Stewart B. McKinney Homeless Assistance Act* and the Interagency Council on the Homeless.

For many years, there have been programs directed to those who were in need. Food stamps have been available through the Department of Agriculture since 1977, and eligibility has been greatly expanded. The Federal Emergency Management Agency (FEMA) has been supplying food and shelter since 1983. However, the increased visibility of the homeless sparked rising concern. A sense that more needed to be done on the federal level

prompted the passage of the *Homeless Housing Assistance Act of 1986*. This was followed in 1987 by the *McKinney Act*, which created a legislative umbrella for programs to assist the homeless.

The *McKinney Act* also established the Interagency Council on the Homeless, consisting of the heads of ten Cabinet Departments (Agriculture, Commerce, Defense, Education, Energy, Health and Human Services, Housing and Urban Development, Interior, Labor, and Transportation) and of five independent Agencies (Action, FEMA, GSA, VA, and the Postal Service). The Low-Income Opportunity Advisory Board is also a member. HUD provides administrative and support services and has been most generous in doing so.

The current council chairperson is Secretary of Housing and Urban Development Samuel R. Pierce, Jr.; the vice chairperson is Secretary of Health and Human Services Otis R. Bowen. The Congress charged the council with broad responsibilities: to collect and disseminate information relating to homeless individuals; to reduce duplication; to provide professional and technical assistance to the field; to review, monitor, and evaluate the program; and to prepare an annual report. To fulfill this mandate will require the cooperation federal, state, and local governments, as well as the assistance of the service providers. We must all work together to discover and develop innovative approaches to the problem. It is this interdisciplinary agenda with which ACIR is concerned. In other words, the theme of this conference relates directly to many of the long-term purposes and goals of the council.

The council's foremost function to date has been implementation of the *McKinney Act*. In FY 1988, $365 million dollars are being directed to these programs. The heaviest burden has fallen on the council's two major Cabinet-level agencies, Housing and Urban Development and Health and Human Services.

HUD's Housing Demonstration Program is developing ways of providing housing and supportive services for homeless persons capable of making the transition to independent living. Nearly $60 million are involved. Greater emphasis has also been placed on housing the elderly and the handicapped. Permanent housing for the homeless handicapped, a particularly difficult client group, is being funded in FY 1987 and FY 1988 at a total of $30 million.

In Health and Human Services, special mention should be made of the mental health block grants to the states to support outreach services and substance abuse treatment, and of the discretionary grants to local public and nonprofit health providers for primary health care, substance abuse, and mental health services. Since this conference is concerned with the public/private "mix" in the delivery of services, I'd like to mention in particular the HUD-HHS-Robert Wood Johnson Program for the Chronically Mentally Ill. The departments and the foundation, together with state and local governments, are sponsoring a multimillion dollar demonstration to support the development of community-based programs and supervised housing for the mentally ill, many of whom are homeless. Nine cities are now participating. The program is a striking example of the results that can be achieved through cooperation and coordination between governmental departments and between those departments and the private sector.

As noted, the mandate of the Interagency Council on the Homeless is to collect and disseminate information on these and other programs, their successes and, inevitably, their failures. From these we hope to draw inferences about which programs best serve the homeless and why. In other words, the council is to serve as a central point of reference, a resource not only for governmental personnel but also for service providers. To this end we have recently published a brochure listing the council's departments and agencies and the phone numbers to be used for inquires. These provide contacts for those who need information and need it quickly. We are publishing a newsletter as a vehicle for interagency and intergovernmental communication and for communication with the field. The newsletter will outline the council's projects, highlight exemplary programs, and review current studies. It will also feature reports from the field.

In order to accomplish the council's goal of providing professional and technical assistance to the field, Secretary Pierce asked the members of the council to designate a coordinator for the homeless in each of their federal regions. These coordinators, now numbering 124, have established a field network, a series of resource centers for all involved in servicing the homeless. They meet on a regular basis, collect and disseminate information, and transmit to Washington reports on activities at the state and local level with special emphasis on the programs of the private sector. Within the universe of homeless, they have a unique opportunity to highlight exemplary efforts while analyzing causes of failure.

The coordinators have also taken the lead in arranging a series of regional conferences to bring together federal and state personnel and local elected officials and service providers. The first conference for Regions V and VII was held in St. Louis on June 28 and 29. Representatives of all levels of government and of local coalitions were able to exchange information, generate ideas, and facilitate future working relationships. The second conference, held in Albuquerque in September for Regions VI and VIII, focused on especially difficult subgroups, such as native Americans and youth.

Finally, the annual report, mandated by the *McKinney Act* and directed by the council, will draw together the experiences of the departments and agencies in Washington and in the field. It will review current studies and reports, analyze and evaluate the programs at the state, local, and federal levels, and highlight those activities that have proved to be most helpful in reaching specific client groups. It will also underline the significant role played by the private, voluntary, nonprofit sector.

The report is to be delivered to the President and to Congress in the fall of 1988. It will give the council and all concerned with the homeless an opportunity to look forward and backward, to review what has been accomplished and to consider what remains to be done. It is designed to deepen our understanding of the problem and to facilitate possible approaches to a solution. Although we may have miles to go before reaching that solution, we are taking concrete steps in the right direction.

Defining the Dimensions of Homelessness

Part I

Homeless Policy: Expansion during Retrenchment

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Although the 1980s have marked a significant retrenchment in U.S. social policy, public social programs have continued to grow. Across the country, for example, a rising number of people slept out of doors, in transportation facilities, and in flophouses, and, gradually, public and private organizations provided more beds. The homeless are one of the largest needy populations to emerge during the last decade, and their advocates represent one of the largest new social movements. Today, financing, regulating, and providing services to the homeless represent a new social function of all U.S. governments, federal, state, and local.

This paper sketches the nature and causes of this emerging problem of homelessness, and assesses some of the directions in the current intergovernmental policy response.

Who Are the Homeless?

Today's homeless people are diverse, and they differ from the traditional so-called "Skid Row bums" and hoboes who rode the rails. The homeless are not only single men but, increasingly, are single women and heads of families and their children. They are not only the elderly but also—now predominantly—under age 40. They are disproportionately from minority groups. Some are alcoholics; some are drug abusers; some are mentally ill; some are all of these; many are none of these. Some are transients, but most are long-time residents of their locales.

We have learned from controversy over the number of homeless in the United States that definitions of homelessness vary. Some definitions include only the obviously or literally homeless who sleep in shelters or in the street.[1] Other definitions include the invisible, borderline, or hidden homeless who are housed in overcrowded, dilapidated, or

unstable conditions. We know also that valid research methodologies are difficult and costly to implement because of the need to computerize longitudinal program utilization data and to conduct street surveys. More important, we know that counts of the homeless are radically sensitive to variations in definition and methodology. Different definitions of homelessness shape different perceptions of the problem and suggest different public policy directions.

Nevertheless, there is agreement on some points. First, the number of homeless persons is large. It is no less than 250,000 to 350,000, the latter number equal to the total population of the city of Portland, Oregon, or Minneapolis.[2] Top estimates of 3 million homeless are equivalent to the population of Los Angeles or Chicago. There is agreement that the homeless are found nationwide and that their number is growing. Sixty metropolitan areas reported an average increase of 10 percent per year between 1980 and 1983;[3] a 25-city survey reported a 25 percent average increase during 1985 and a 20 percent average increase during 1986, with no decrease expected. It has been found, too, that the homeless are composed of three groups: about 56 percent are single men, 15 percent are single women, and 28 percent are heads of families with children.[4] First to increase in the late 1970s were single men, followed by single women. During the last five years, however, families have been the fastest growing group. Twenty-four out of 25 cities reported in a 1987 survey that the number of families requesting emergency shelter increased over the last two years by an average of 31 percent.[5]

The common denominator among the homeless is simply their need for housing—a point that is sometimes obscured in policy deliberations. The homeless do not have a routine place to sleep in private accommodation, and they live from pillar to post in temporary quarters, often in public places. The need for housing differs between the singles and families. This difference occurs chiefly because of the support systems that children require, particularly attendance at school, low-cost day care, and food to be refrigerated, cooked, and served in a private setting.

One of the most important characteristics common to the homeless is their poverty. While as many as 25 percent of homeless adults receive some income from employment (which is usually part time or irregular), about half maintain themselves by begging, selling blood, collecting and selling cans, scavenging garbage cans for food, or receiving donations of some sort.[6] About 30 percent use government programs for their income. They divide into three groups: (1) a state aided population of single persons who are not eligible for federal income assistance; (2) a nationally assisted population that receives veterans' benefits or Supplemental Security Income (SSI); and (3) poor families who qualify for Aid to Families with Dependent Children (AFDC), in which federal and state governments share costs and rulemaking authority. These government sources set allowances for rent that are usually used in the private housing market and are usually payable without regard to the quality of housing.

Perhaps the most salient difference between homeless people who are single and those with children is the larger incidence of mental illness among singles. Homeless family heads rarely exhibit severe mental illness, while among singles the incidence can be as low as 10 percent or as high as 50 percent, depending in part on the criteria of measurement.[7] Studies do show that some homeless family heads experience personality disorders, anxiety, and depression.[8] It is not clear, however, to what extent these problems preceded homelessness or impede the ability to maintain a residence. Some homeless families experience social problems other than severe mental illness, including domestic violence, child abuse, child neglect, and foster care placement, although it is unknown how the incidence differs from other populations.

Causes of Homelessness

Most research on the homeless has been fragmentary and descriptive of particular subpopulations and locations. Less attention has been given to comprehensive investigations of the principal causes of homelessness.[9] At this stage of research, four main hypotheses can be advanced to explain the recent rise of homelessness: (1) lack of affordable housing; (2) lack of income; (3) personal characteristics of the homeless; and (4) public policies.

Lack of Affordable Housing

Some analysts have found that homelessness has resulted from maladjustments in inner city housing markets, which have made it difficult for low-income people to find affordable and suitable housing.[10] Other analysts attribute homelessness in part to extremely tight housing markets, but consider the housing crisis to be a necessary though not sufficient condition.[11] In a particular location, adequacy of the supply of low-rent housing can be estimated by measures such as the vacancy rates for units at all rent levels and particularly for low-rent units, the availability of vacant low-rent apartments compared to the number of families on AFDC and other income-tested programs, the incidence and severity of overcrowding and the rate of overcrowding among low-income groups, rent to income ratios, and the frequency of moves among the income-assisted population.

Two theories have been developed to explain the causes of scarcity of low-rent housing. The first theory points to the urban redevelopment process and underscores the decay of housing stock in post-industrial cities and shifts in reinvestment that exclude the poor.[12] This theory highlights the displacement of poor renters caused by several connected processes. One is gentrification, namely, the attraction of private capital to renew central cities, which encourages the middle class (the "new gentry") to remain in or move to revitalized neighborhoods. An associated process causing displacement is abandonment of buildings by private landlords. Dwindling construction of new units also may produce scarcity.

An alternate theory of causes of housing scarcity emphasizes public regulation that may discourage housing investment and residential mobility. Cited most prominently is government regulation of rent, through rent control or rent stabilization programs,[13] although some analysts believe evidence for this theory is inconclusive.[14]

Inadequate Income

A second factor that may contribute to homelessness is scarcity of personal income. Are more families homeless because more families are very poor? Three measures of drop in income could be tested in particular locations: whether poverty rates have increased; whether unemployment rates have increased; and whether participation in income-tested programs such as AFDC has increased during a given period of time. Adequacy of income can be tested also as a relative measure, that is, income in comparison to its purchasing power in the housing market: what proportion of income do people pay for rent, and how do rent allowances in public programs, such as AFDC, compare to rent levels actually charged by landlords? Even if absolute measures of income are stable, the purchasing power of income relative to rent charged in the housing market may deteriorate.

Personal Characteristics

Two hypotheses could be tested on a causal relationship between personal characteristics and homelessness. One, changes in rates of characteristics, such as mental illness, personality disorders, or alcohol and drug abuse, could cause homelessness. Two, opportunistic attitudes may motivate the poor to seek public shelter, even though adequate private arrangements are available. Some analysts have asserted that increasing the supply of shelter beds generates more demand,[15] a process that some observers have dubbed the "woodwork effect." A contrary theory contends that nonmonetary prices and congestion can ration use of public services[16] and would discourage use of shelters. The opportunism hypothesis may be weaker than the rationing hypothesis, if certain conditions exist, such as poor shelter facilities, long length of shelter stays, and distance of shelters from community of origin.

Public Policies

Does scarcity in the housing market for the very poor result only from decisions by private landlords, or can prior public policy contribute to scarcity? The impact of at least eight public policies could be assessed: (1) cuts in federal housing grants for construction, renovation, loans, and rent abatement; (2) maximum rent allowances in means-tested public programs; (3) real estate collection and foreclosure policies, particularly concerning reassessment, timing, and enforcement; (4) tax abatement for private developers, particularly of single-room occupancy hotels; (5) zoning of land use in cities and suburbs, and the approval process for construction; (6) regulating or failing to regulate redlining by banks; (7) regulating or failing to regulate the warehousing of vacant apartments by landlords; and (8) rent regulation.

In sum, the most important factor in explaining the dramatic rise in the homeless in the U.S. is a change in the housing market, which created an acute scarcity of units affordable by the very poor.

Assessing Causes and Characteristics

In searching for causes of homelessness, it is notable that descriptive characteristics of the homeless are not necessarily the same as the causal factors that produce homelessness. Do people who are homeless and mentally ill find themselves homeless because they are mentally ill? Are poor people who are homeless without a home because they are poor? People can be mentally ill under their own roofs or on the street. Persons with such characteristics as severe mental illness, low education, minority status, being female or a mother of small children, or having a criminal record, do tend to be at a disadvantage in competing in the private labor market. Therefore, they tend not to receive wages that are regular, full time, year round, much above the legal minimum, or sufficient to make them geographically mobile; ordinarily, they are not in positions that lead to advancement in pay or enable them to be covered by private health insurance. Such conditions place these groups in the poverty population in numbers disproportionate to their share of the total population.

Although these characteristics predict poverty, they do not inevitably cause homelessness if the supply of low-rent housing is adequate. Severe mental illness and criminality can even qualify a person to enter institutional housing which, along with obvious negatives, at least provides a roof and a bed off the street. Nevertheless, personal character-

istics that handicap competitiveness in the labor market help to explain why these particular people are the ones who disproportionately become the odd ones out in a market where housing units are scarce. Fundamentally, homelessness among the poor is caused by a lack of vacant housing available at a rock bottom price.

The main problem, therefore, is to explain the scarcity of housing at rents affordable to the poor. Because many of the homeless are eligible for income assistance programs, the rent levels they can pay are set by government policy. Often, this government assistance is so low that recipients can use only a bottom fraction of the housing market, where vacancies may be the tightest. This condition compounds the multiple and interactive causes of homelessness that must be kept in perspective for various subpopulations and locations over time.

Policy Responses

With few exceptions, the response to homelessness across the U.S. has not been to provide permanent housing. Instead, the predominant response has been to open temporary shelters. By their physical design and administrative rules, shelters are intended for short-term use, for single nights or, for families, several months. Some shelters for individuals are barracks-like rooms with cots close together, no privacy, rules against bringing in personal belongings, showers en masse, body inspections, and eviction at dawn. While some family shelters have similar conditions, others offer single rooms per family for longer stays. Nevertheless, family shelters also can have cramped quarters, little privacy, shared bathrooms, little or no refrigeration for food, minimal or no cooking facilities, and be located at a distance from schools, day care centers, grocery stores, hospitals, and communities of origin.

Why have government and nonprofit agencies tended to choose temporary shelter over the alternative of creating permanent housing for poor families? At least three reasons can be discerned: (1) the definition of homelessness as a temporary crisis, (2) organizational and cost limitations, and (3) political feasibility.

First, opening temporary shelters was an emergency response to a problem that was perceived to be an acute crisis of only short duration. Homelessness tends to be seen as a one-shot catastrophe, like a flood, hurricane, or earthquake. Natural disasters occur suddenly, take people by surprise, and end in minutes or days. A natural disaster entails human deprivation, dislocation, shortages in economic markets, and, potentially, disruption of civil order. Crisis arouses demands for rapid collective action, and people may turn to government as their authoritative agent. Ordinarily, the immediate response is to provide emergency services.

In the case of homelessness, the sight of increased numbers of people sleeping and begging in streets, parks, and bus stations carried visual emotional impact. Newspapers and television ran pictures, serial stories on a daily basis, and features on individuals in need. Drama centered on risks of life and death and the seasonal pressure to race against time. Skid Row flophouses and charitable agencies were overflowing. Could shelters open more beds before winter? Would someone freeze in the street? The public's usual acceptance of vagrancy as an invisible but "normal" chronic social problem was disturbed by the larger number of visibly homeless persons on the streets in the 1980s. A sense of crisis shaped the definition of the homeless problem as an acute disaster demanding immediate emergency action. In this climate, policy prescriptions focused primarily on the most visible and immediate human needs.

A second reason for the choice of temporary shelters was the organizational and cost advantages of temporary accommodations. Paying for floor space for purposes such as sleeping and eating is expensive. When residence is a component of service, cost skyrockets. Housing people in jails with barest essentials costs thousands of dollars per person per year, as does housing people in foster placement, hospitals, nursing homes, college dormitories, or boarding schools. Given that even rudimentary residential service is expensive, the opportunity to reduce cost is only to increase density or decrease amenities. Construction of permanent housing requires large amounts of capital invested up front, and this level of financial commitment was not available and was not supportable by the political consensus at the time.

The organizational advantage of choosing temporary shelter instead of permanent housing was that existing facilities could be converted more easily to temporary than to long-term residence. When state and local governments did finance or operate shelters, they could use former schools, hospitals, or armories. More important, for the most part, states and cities relied on religious and charitable organizations to respond to the requests of the homeless.[17] Shelter services were within the organizational capacities of many private nonprofit agencies. Churches could set up a dozen cots, arrange for laundry and bathing services, recruit volunteers, and provide some food, within the scope of their existing knowledge, resources, and physical structures. Thus, government agencies could regulate and sometimes fund private nonprofit efforts without experiencing traumatic organizational change themselves. Most nonprofit organizations had no prior experience in

financing and operating permanent housing that involves substantial risk.

The third reason for the tendency to choose the shelter alternative was its political feasibility in comparison to permanent housing. Expansion of services for the homeless was fed by challenges from advocacy communities, the media, and, in some cases, state courts. Nevertheless, action risked political costs from other quarters. Public officials, for example, had to overcome opposition from some communities and elected politicians who fought the location of shelters in their neighborhoods, an attitude now called "NIMBY" (not in my back yard). Even some religious organizations with a few cots in their basements have been challenged on the ground that such shelters violate zoning regulations.[18] To overcome opposition, public officials have needed to communicate an overriding sense of crisis. To portray the crisis as temporary gave critics the expectation that public financing would be short term and that shelters would soon close. Interpreting homelessness as a temporary crisis allowed political officials initially to assert that only an emergency response was appropriate to the problem.

Defining the problem as a crisis also enabled public officials to select fiscal strategies that were short-term emergency measures rather than long-term programs. Notably, initial national legislation passed in 1983 and 1984 gave appropriations to the Federal Emergency Management Agency, whose mission is to aid communities recovering from short-term natural disasters and whose officials had no experience running a permanent program.[19] Also, state governments could use the emergency assistance provisions of AFDC, but they could not extend payments beyond the short emergency period.

Defining homelessness as a temporary crisis had the effect of protecting local, state, and national governments from having to seek new revenues for permanent housing during a period of extraordinary national deficit and fiscal conservatism in national government. Cuts in federal financing of housing and other social programs generated many new competing demands on state and local revenues. State and local financing of large-scale permanent housing for low-income families has not been a historical function of state and local government. To leap to a new social function that would require extraordinary amounts of capital investment and high levels of financial and political risk was therefore unlikely. Investment in temporary shelter, although expensive, was less expensive, less risky, and had wider political acceptance.

Defining the problem as a crisis and selecting emergency strategies shaped the new public function as a minimal and temporary form of social protection. The advantage of the crisis response was that it permitted a rapid start that could be minimally acceptable among all opinion groups for at least a short period.

The establishment of publicly financed, regulated, or provided services intended to meet the bare essentials of survival is traditional to U.S. government. The historical core of U.S. national and subnational welfare programs is the provision of services that are essentially protective and not preventive or auxiliary. The main U.S. social programs provide the fundamentals of social protection, the now proverbial "floor" or "safety net," for which there is the broadest political agreement on the appropriate role of government. Thus, temporary shelters for emergency needs are well within the traditional definition of legitimate social protection functions of U.S. government. This helps to explain why, during a period of historical social retrenchment, funds for a new social function could be created even by a Congress and state and local officials who believed in minimizing the scope of government social policy.

However, unplanned long-term stays in high-density shelters, particularly when children are present, can attract public criticism. As demands rise to upgrade the living conditions of quarters designed to be temporary, cost also will escalate. Ironically, where even high-density temporary accommodation is scarce, cost can exceed the rent levels allowed by AFDC in permanent private housing. Thus, the problem now faced by local governments where homeless populations have been the longest, is whether a temporary shelter system, based on a crisis rationale, can still minimally satisfy the standards of consumers, public opinion, state regulations, elected officials, and, in some locations, state courts.

Future Policy Directions

In assessing future policy directions, questions can focus on policy content and policy means. Three main questions arise regarding future policy content: (1) how to assess an appropriate mix of temporary shelter, transitional shelter, and permanent housing; (2) how to determine an appropriate balance between a "housing only" policy and a "housing plus" policy; and (3) the role of planning, evaluation, and coordination.

The Shelter-Housing Mix

First, the concept has emerged of a three-tier response to homelessness: temporary shelter, transitional shelter, and permanent housing. Policy prescriptions on the appropriate mix among these three are consciously and unconsciously shaped by assumptions about the nature of the homeless problem and about the appropriate relationship between public social investment and private economic investment. The traditional assumptions are that supplying

permanent housing in the U.S. is a function that belongs principally to the private sector, and the public role is residual and directed mainly toward people who cannot effectively compete in the private market. If homelessness is indeed a temporary condition, then high-density temporary shelter may be an appropriate solution—like youth hostels for travelers—and government need not increase investment in permanent housing.

However, there is not, at least not yet, any indication that the homeless population is decreasing or even leveling off. As this recognition has spread, recent federal legislation and some state actions have begun to expand transitional shelter and permanent housing. If concern were only for the people in need, the preferred policy choice would be permanent housing. However, its high cost and the expanded government role that would occur deter political agreement to go that route. In this context, the rationale for transitional housing has strong appeal, and therefore requires special attention.

Transitional shelter is an intermediate form of service between temporary shelters and permanent housing. Transitional shelter differs from temporary shelter because its physical design—including more space, privacy, and cooking facilities—is intended for medium-term stays. Transitional shelters can also provide enriched services, such as counseling, employment referral, and health screening. Transitional shelter resembles temporary shelter, however, because the length of stay is limited by regulation, usually for fixed periods, such as 6 to 12 months. Development of the idea of transitional shelter arose partly out of the need for political compromise, and it represents a way station between short-term shelters and long-term housing.

Despite the appeal of transitional shelter, it cannot substitute for permanent housing in a scare market. When shelter residents cannot locate permanent housing and overstay the time limit, public and private agencies find themselves required to evict their own consumers. Another limitation can be that the enriched services available by virtue of residence in a transitional shelter disappear when consumers move out, and this lack could aggravate recidivism. The challenge for government and nonprofits would be to make available in-home services (much as home care and preventive services continue outside residential hospital and foster care institutions), but the cost is a barrier.

Many observers also feel that public policy should not reserve transitional shelter and permanent housing only for ex-residents of temporary shelters. Some policymakers fear that some consumers would use shelters not out of dire need but solely as an opportunistic avenue to preferred housing. For this and other reasons, transitional shelter is usually rationed by administrative rules and is typically limited to people with definable special characteristics, such as victims of domestic violence, families burned out of their homes, pregnant women, mothers of infants, employable persons, youth, veterans, or the elderly. Such policies place transitional shelter within the traditional pattern of U.S. social policy that restricts eligibility to certain identifiable subgroups who are considered to be most deserving. Transitional shelter, therefore, is a piecemeal and partial response which is clearly necessary, but it cannot universally resolve homelessness in a scarce housing market.

A Housing-Plus Strategy

A second question of policy content concerns how to assess an appropriate balance between a "housing only" policy and a "housing plus" policy. A housing-plus strategy would entail not only provision of temporary shelter or permanent housing but also higher income assistance levels, increased opportunity for employment training and job placement, provision of accessible health care counseling, and other services for supported living, prevention of child abuse and neglect, and prevention of foster care placement.

Such a housing-plus policy would cut across many traditional policy sectors. Development of intersectoral policy calls for conceptualization of services for the homeless in a comprehensive framework. Many health professionals have come to define health from an ecological viewpoint, broadly defining health needs to include any economic or social factors that may tend to diminish the physical or mental health of the population. An eclectic definition of health, therefore, calls for conceptualizing policy not only in the narrow spheres that we have historically developed but also as comprehensive intersectoral policy.

Intersectoral policy on the homeless is emerging, and its broad scope is signaled by the facts that action by ten House and Senate committees was necessary for passage of the *Stewart B. McKinney Homeless Assistance Act of 1987* (*McKinney Act*) and that 15 federal agencies are members of the Interagency Council on the Homeless. A turn toward intersectoral policy is evident in the *McKinney* legislation which, in addition to housing and emergency food and shelter, authorized about $200 million each in 1987 and 1988 for health, job training, education, nutrition, and community services.

Planning, Evaluation, and Coordination

A third contemporary policy question concerns the role of planning, evaluation, and coordination. Because the homeless population is so diverse and their needs cut across many policy sectors, the rationale for planning, evaluation, and coordination

is evident. The regulatory role of state and local governments should include the functions of planning, evaluation, and coordination, even if they do not fund or operate shelters. After a half-century of growth of nationally sponsored social programs, the cry for planning, evaluation, and coordination is familiar, and the need is now widely recognized by scholars and policymakers. Yet, the instances of successful planning, evaluation, and coordination are not as numerous as might be hoped, and even successful cases often face opposition. Nevertheless, public and private organizations across the states today include numerous professional and lay people who are experienced in these fields and have learned the requisite technical and political skills. For this reason, planning, evaluation, and coordination probably will be demanded not only by the advocate community but also by state and local governments. Congressional creation of the Interagency Council on the Homeless reinforces this view.

The Public-Private Mix of Services

Regarding the public-private mix in the delivery system, there is a reliance nationwide on private nonprofit organizations to shelter the homeless. Traditionally in the U.S., private nonprofit agencies have filled service gaps in the profit-making economy. For example, when young men migrating to industrializing towns found jobs but no rooms to rent, the YMCA-YMHA's opened residential hotels to tide them over. More than is generally realized, U.S. social programs tend to rely on private organizations to provide services that are publicly financed and regulated. Medicare, Food Stamps, SSI, Head Start, Medicaid, AFDC, and day care under the Social Security Act, for example, are fundamentally mechanisms to enable beneficiaries to obtain goods and services from a local market that distributes food, shelter, clothing, health care, and preschool services largely through the private economy, including profit and nonprofit producers. Thus, privatization in these programs did not reflect the cost cutting reforms of the 1980s so much as service expansion strategy with a long-standing history.

Following this pattern, new providers of temporary shelter in the 1980s were often private nonprofit organizations that were regulated and sometimes partially financed by government under a contract, fee, or other mechanism. The organizational and cost advantages of temporary shelter, as noted above, enabled government officials to rely on providers in the private nonprofit sector. Nonprofits are moving toward operation of transitional shelters, and appear to be suited to the delivery of comprehensive services because many have prior experience in the social and health sectors.

The advantage of using the private nonprofit system to deliver temporary and transitional shelter is to utilize their expertise and administrative networks, and to achieve the benefits of decentralization, which is necessary to reach rapidly a diverse population that may be geographically dispersed. Moreover, the political advantage of involving nonprofit organizations is to win the support of their boards, constituencies, and professionals so that they can educate political elites and the public regarding the need for service. Thus, the role of nonprofits in temporary and transitional shelter is traditional, is expanding, and is salutary.

However, overreliance on nonprofits for provision of permanent housing for the poor is misplaced, for the reasons of cost, risk, and inexperience noted above. Although nonprofits have, can, and will own and operate housing, they have been underrepresented in the housing delivery system and should be encouraged to increase their role. Nonetheless, government cannot expect them to tackle the entire housing problem. Concurrent government action is crucial, particularly to create and package financing, and to underwrite significant and prolonged technical assistance.

Missing from the private delivery system of temporary and transitional shelter, as well as permanent housing, has been a resurgence of for-profit enterprise. With few exceptions, for-profit corporations have not taken an independent initiative in the homelessness crisis to develop new ventures, new combinations of financing, or more economical methods of construction and rehabilitation that would enable them to expand shelter or housing for the poor. Where for-profit organizations have responded, it is often because government has activated them with financial incentives. It appears likely, therefore, that government will have to expand its financing and regulation of the private housing industry.

Funding Sources

The U.S. has traditionally relied on the filtering process in the private market to provide deteriorated housing to low-income renters. It appears now, however, that at current levels of government housing investment, the private economy cannot meet the need. As public financing of temporary and transitional shelter gradually expands, two policy choices are possible.

First, the bulk of new public investment can continue to be in temporary and transitional shelter. Assuming need remains constant or increases, this option would cement a new public social function into the housing supply system. It seems necessary to accept indefinitely a level of temporary and transitional shelter that is much expanded over the 1970s. Providing temporary and transitional shelter can delay the need for creating permanent housing, but as homelessness increases, these emergency re-

sponses become de facto, unplanned, and undesirable permanent housing, which can even cost more per beneficiary than permanent housing. In these circumstances, it is more likely that support will grow for increased public financing of permanent housing.

A second alternative is that public investment in permanent housing could increase. A shift toward increasing federal financing of low-income housing was in evidence in congressional authorizations in 1987. However, it appears unlikely in the present political environment that future federal housing support will much exceed, or even resume, pre-1981 levels. Lacking that resource, the question becomes whether state legislatures will finance significantly higher levels of affordable housing. The 1980s have witnessed a surge in lobbying for business and consumer issues in state legislatures. If the federal government does not significantly expand permanent affordable housing, one can expect advocates to increase activity in state legislative and executive offices, possibly more than in the courtroom. States where advocates have won successful court litigation had pertinent protections in their state constitution, statutes, or regulations. These protections were very important in some locations in securing emergency shelter for the homeless, but all states do not have the same laws.[20] Also, courts have found that while legal standards may require minimal social protection (that is, temporary or transitional shelter for emergency needs), they do not guarantee permanent housing.

Policy Recommendations

The perspective generated by this investigation signals the idea that policy debate on homelessness must lead to a reinvigorated consideration of federal, state, and local housing policy.[21] As the incidence of homelessness shows no sign of abating, it becomes more likely that elected officials will recognize the need to expand publicly subsidized permanent housing. What targets are appropriate? In the history of national housing policy, analysis of need factors has produced goals for adequately housing the U.S. population. However, in the current conditions of national deficit, political equivocation, and increasing homelessness, attention is drawn not so much to ideal policy standards for housing supply as to minimal beginnings.

Achieving a replacement level is a start. At least, restore public subsidy of new low-rent housing units at the rate of expansion that the U.S. had before 1981. At least, restore the low-rent housing units that were lost to the destruction of abandoned buildings and to gentrification and conversion to high rental units, cooperatives, and condominiums. At least, ensure that the deinstitutionalized mentally ill have a bed they can come back to, to sleep in every night, a bed they would have if they were institutionalized. At least, make the same assurance for people who are discharged from other publicly financed institutions, such as foster homes, hospitals, prisons, and drug treatment centers. At least, ensure that people who are severely and chronically mentally ill can reside, as needed, in health care institutions. At least, when individuals and families who pay their rent from public income assistance programs receive an eviction notice, take extra steps to stop it, or quickly help them to find new quarters. At least, use existing assistance programs, such as AFDC, to pay back rent, moving expenses, finders fees, or rent deposits. Encourage expanding initiatives to finance housing at state and local levels, with the growth of housing trust funds, inclusionary zoning, revenue bonds, and regulations requiring developers to set aside space or money for low cost-housing. At least, plan and ensure that all geographic jurisdictions have low-cost housing available for their "fair share" of very poor people.

An income policy is also important, but it cannot replace direct augmentation of low-rent housing supplies. Will income subsidy in the foreseeable future be high enough to narrow the distribution curve significantly? Won't there remain a long low end of the income curve? How will these still relatively low-income people compete where very low-rent housing is scarce?

A service policy is also essential. However, due to political infeasibility, services are likely to cover only portions of the population in need. And services cannot substitute for permanent housing. Although such services will enable some homeless people to become regularly employed, and may eventually enable them to pay rent with their own earnings, a majority will not be able to do so.

Having a roof and a bed to sleep in, every night, indefinitely, is of course in no way a guarantor that all of a person's needs will be met. Income for food; education and day care for jobs; medical and social services to treat and prevent illness, mental illness, child abuse, and drug and alcohol abuse are all requisites. None of these, however, can substitute for housing, and many are ineffective if housing is missing.

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Discussion Paper: Implications of the Low-Income Housing Ratio for National Homelessness Policy

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Professor Kirchheimer has provided overviews of the causes of homelessness. "Causes" are important, because they lead directly to "solutions."

Views on the causes of homelessness held by the public and by elected officials will have a direct influence on public policy. A mayor who thinks of family homelessness primarily as a short-term emergency problem—burned-out families, mothers fleeing domestic violence—will emphasize short-term emergency solutions, such as shelters. A mayor who thinks families are homeless because mothers are "incompetent"—they don't have adequate "living skills" or they are psychiatrically disabled—may emphasize transitional living programs with extensive social services and psychiatric case work. Mayors who share the view that providing shelter brings poor families "out of the woodwork" or causes homeless families from other cities to move to their jurisdictions may support no program for homeless families at all. Ideas—the mental images we hold—are important.

The weight of the evidence supports a shortage of affordable low-income housing as *the* cause of homelessness in the 1980s. Professor Dolbeare details the changes in the low-income housing ratio over time. There is a growing discrepancy between the number of poor households that can afford only low-income housing and the number of such housing units available.

At the aggregate level, the cause of homelessness is simple: When the number of poor households exceeds the number of low-income housing units, a shortage of low-income housing exists. When that happens, households do two things. Those that can pay more for their housing will do so. Those that can't

pay more may double up with family or friends. The remainder becomes homeless—it's as simple as that. When the number of poor households far exceeds the number of low-income housing units, homelessness is the inevitable result.

What about the competing hypotheses? Are they plausible? Is homelessness a matter of a need for emergency housing and not of a shortage of permanent, affordable low-income housing? If that were true in the aggregate, you would have to show that the number of emergencies has been steadily increasing during the 1980s. You would have to show that the incidence of domestic violence or the incidence of residential fires, for example, is radically different in the 1980s than it was during preceding years. There is no evidence to support this. What has changed is not the number of emergencies, but the number of low-income housing units.

Likewise, consider the hypothesis that incompetent or psychiatrically disturbed mothers are the cause of family homelessness. At the individual level, this might seem like an explanation. But that just doesn't make sense in the aggregate. The long-term AFDC recipient who can be labeled "multiproblem" and who needs several services now had the same characteristics ten years ago. It is not the characteristics of the mothers that have changed, but the characteristics of the low-income housing market.

If homelessness is the result of the fact that there are more poor households than there are low-income housing units, the only effective strategies will be those that either increase the number of low-income housing units or decrease the number of poor households that are competing for those units.

What are the public policy implications of this view of the causes of homelessness? In short, the implications are: (1) shelters are not a solution for homelessness; (2) stand-alone service delivery is not a solution for homelessness; (3) transitional housing is not a solution for homelessness. Since these may be seen as somewhat radical stands, I would like to explore them in a bit more depth.

First, shelters are not a solution for homelessness. We do need shelters. Mothers who are fleeing domestic violence need emergency shelter; so do all families who have run out of other options and will face the street if emergency shelter is not provided. In Los Angeles, as in other jurisdictions where adequate emergency shelter is not provided, there are mothers with infants who will sleep tonight in a laundry room, in the back of an open truck, or in a grocery store parking lot, because they have no other options.

Emergency shelters, however, are at best a "band-aid" approach. They will have no effect on the total number of households that do not have access to permanent, affordable low-income housing. Communities need to understand that no matter how much time and money, how much community support and political goodwill they expend on emergency shelters, homelessness will continue to grow.

Second, the mere delivery of services will not solve homelessness. It doesn't make sense to give a mother a prescription for antidepressants and then send her back to a shelter, when the reason she is depressed is that she has been living with her husband and three children in the airport for two months and the reason she is having suicidal thoughts is that they are going to be discharged from the shelter back into the streets. She needs mental health services. Her husband needs employment and training services. But give them services with housing, not services instead of housing.

Third, transitional housing is not a substitute for permanent housing. Some families—in my opinion, a relative few—really need supported housing with extensive social services because there is little chance that they will be able to live independently if given only housing.

But the real problem with transitional living programs is that they do not add any units to the total pool of low-income housing. Even assuming that graduates of transitional living programs are more competitive in the rental housing market due to the training in living skills they have received, as they move into permanent, affordable housing they will merely displace other poor households that would have occupied the same units. At best, when seen from the view of the overall low-income housing shortage, transitional living programs provide a few additional units of low-income housing through which the poor are forced to rotate at six-month intervals. That is not to say that transitional living programs don't provide real benefits to individual families. Sometimes they do. But they do not solve the overall problem.

Emergency shelters, service delivery, and transitional housing programs are the three most common types of programs being used to deal with homelessness. But none of them actually does anything to deal with the underlying problem—there are more poor households than there are affordable low-income housing units. In short, no matter how much money is spent on emergency shelters or stand-alone service delivery or transitional living programs, homelessness will continue to increase.

Professor Kirchheimer ends her paper by saying, "The scope of this investigation is homelessness, and discussion of alternatives in national housing policy is beyond our perimeter." I disagree. Discussion of alternatives in housing policy and alternatives in poverty policy has to be what this conference is all about. As Professor Kirchheimer points out, "Our

country has traditionally relied on the filtering process in the private market to provide deteriorated housing to low-income renters. . . . It appears now, however, that . . . the private economy cannot meet the need."

Indeed, the private economy cannot meet the need for an adequate supply of affordable low-income housing. There is not enough deteriorated housing left, and there has not been a profit in building or maintaining low-income housing for years. Therefore, we have a choice. Either government will alter its course and step in and fill the need for affordable permanent housing, or homelessness and its attendant human misery will continue to grow.

The task of the conference is to explore the question, "In an era of federal retrenchment, how can state and local governments respond effectively to the needs of homeless citizens?" I would like to offer a few suggestions.

First, take a stand. We will hear later from representatives of a state that has one of the most comprehensive, well-planned programs for the homeless. It isn't perfect, but it's superior to programs in many other states. In my opinion, the reason that Massachusetts has such a program is that the governor took a stand. Basically, he said: "We are not going to have mothers with babies living in the streets of Massachusetts." And, as a result, they don't. He made homelessness a priority of his administration. We need this kind of leadership. We need leaders who are willing to take a stand against poverty. If you don't have such a leader in your jurisdiction, elect one.

Second, educate. While you are looking for leaders who will make poverty a priority, build grass roots support. As Professor Kirchheimer said, there is not yet in this nation a political consensus for the major changes in housing policy and in poverty policy that will be necessary in order to stem the tide of homelessness. Before such a consensus can emerge, people must know the facts. Educate your citizens, your local and state officials. Educate your senators and representatives. Let them know that homelessness is a poverty problem and a housing problem, not a personal problem. Help them to see that if no change in public policy is forthcoming the crisis will worsen. To continue the delusion that the homeless themselves are responsible for their plight—the old "undeserving poor" idea—can only lead to a catastrophe that will dwarf the present crisis.

Third, regarding intergovernmental relations: lobby. The administration suggests that in an era of federal fiscal retrenchment, local and state governments, private nonprofits, and private citizens will have to do most of it by themselves. Historically, as Professor Kirchheimer has pointed out, the financing of permanent housing for low-income households has never been a function of state and local government. Likewise, major impetus for poverty programs has typically come from the federal government. It is not possible for private citizens and local governments to do it on their own. The *McKinney Act* is a start, but a greater federal commitment will be needed in order to make a real dent in long-term poverty and homelessness.

Fourth, cooperate, coordinate, and plan. We got ourselves into this mess as a nation partially because we were not looking at the big picture over the long term. We encouraged the destruction of the low-income housing stock and decimated HUD's low-income housing budget while allowing unindexed income support benefits to deteriorate and cutting back benefits and programs for the poor. That wasn't very smart, and we're paying for it now in human misery. We need comprehensive intersectoral policy initiatives with broad scope and vision. The U.S. political process is not very good at encouraging long-range comprehensive planning (witness the efforts to reduce the federal budget deficit), but we must try.

The responsible course is to acknowledge that the homeless are victims of bad policy and poor planning, and to begin now to build new low-income units and preserve existing ones, while providing child care and the opportunity to work to all who want it.

The Deinstitutionalization of the Mentally Ill

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The growing problem of homelessness has emerged as a national tragedy, which is commanding attention from all segments of society, including the federal, state, and local governments, the media, and the public at large. A substantial portion of the homeless are chronically and severely mentally ill individuals who in years past would have been long-term residents of state hospitals. They now have no place to live because the efforts to depopulate public hospitals over the past two decades were coupled with unavailability of suitable housing and supervised living arrangements in "the community," inadequate continuing medical-psychiatric care and other supportive services, and poorly thought-out changes in the laws governing involuntary treatment.

The homeless mentally ill are those homeless persons disabled by chronic major mental illness—schizophrenia, manic-depressive disorder, and major depression. The most methodologically sound studies thus far indicate that, among the total population of homeless persons, about one-third to two-fifths suffer from a major mental illness.[1] Another way of defining this population is those persons who would have lived out their lives in state hospitals prior to deinstitutionalization. Is deinstitutionalization the cause of homelessness? Some would say yes, and send the chronically mentally ill back to the hospitals. A main thesis of this paper, however, is that homelessness among the mentally ill is not the result of deinstitutionalization per se but of the problems of implementation and the related problem of a lack of a clear understanding of the needs of the chronically mentally ill in the community. The discussion then turns to some additional unintended results of these problems, such as criminalization of the mentally ill, which usually accompanies homelessness. The paper

concludes with some ways of resolving these problems.

The Link between Deinstitutionalization and Homelessness

To see the appalling conditions under which the homeless mentally ill exist has a profound impact on us; our natural reaction is to want to rectify the horrors of what we see with a quick, bold stroke. For the chronically mentally ill, however, homelessness is a complex problem with multiple causes; in analyzing this problem we need to guard against settling for simplistic explanations and solutions. For instance, homelessness is closely linked with deinstitutionalization in the sense that three decades ago most of the chronically mentally ill had a home—the state hospital. Without deinstitutionalization, it is unlikely that there would be large numbers of homeless mentally ill. Thus, in countries where deinstitutionalization has barely begun, homelessness of the chronically mentally ill is not a significant problem. But that does not mean we can simply explain homelessness as a result of deinstitutionalization; we have to look at the conditions that these mentally ill persons must face in the community, the lack of needed resources, and the nature of mental illness.

With the infusion of the chronically mentally ill into the community, we are now faced with the need to understand their reaction to and tolerance of the stresses of community life and determine what has become of them, and why, without the state hospitals. It has been documented nationwide that substantial numbers of the severely mentally ill are homeless at any given time.[2] Some are homeless continuously, and some intermittently.[3] We need to understand what characteristics of society and of the mentally ill have interacted to produce such an unforeseen and grave problem as homelessness. Without that understanding, we will not be able to conceptualize and then implement what needs to be done to resolve the problems of homelessness.

A Brief History of Deinstitutionalization

For more than half of this century, the state hospitals kept the mentally ill out of sight and out of mind. Moreover, the controls and structure provided by the state hospitals, as well as the granting of almost total asylum, may have been necessary for many of the long-term mentally ill before the advent of modern psychoactive medications. Unfortunately, the ways in which state hospitals achieved this structure and asylum led to everyday abuses that have left scars on the mental health professionals as well as on the patients.

The stage was set for deinstitutionalization by periodic public outcries about these deplorable conditions, documented by journalists such as Albert Deutsch in the 1940s and 1950s.[4] Mental health professionals and their organizational leaders also expressed growing concern. These concerns led ultimately to the formation of the Joint Commission on Mental Illness and Health in 1955. The commission's recommendations for community alternatives to state hospitals were published in 1961 as *Action for Mental Health*.[5]

When the new psychoactive medications appeared,[6] along with a new philosophy of social treatment,[7] the majority of the chronic psychotic population was left in a state hospital environment that was now clearly unnecessary and even inappropriate for them, though, as noted later, it still met many of their needs. Other factors also came into play. First, there was a conviction that mental patients would receive better and more humanitarian treatment in the community than in state hospitals far removed from home. This belief was a philosophical keystone in the origins of the community mental health movement. Another powerful motivating force was concern about the civil rights of psychiatric patients; the systems then employed of indefinite, often lifelong, commitment and institutionalization with little due process deprived them of their civil rights. Not the least of the motivating factors was financial. State governments wished to shift some of the fiscal burden for these patients to federal and local governments—that is, to federal Supplemental Security Income (SSI) and Medicaid, and local law enforcement agencies and emergency health and mental health services.[8]

The process of deinstitutionalization was accelerated considerably by two significant federal developments in 1963. First, categorical Aid to the Disabled (ATD) became available to the mentally ill, which made them eligible for the first time for federal financial support in the community. Second, the Congress enacted legislation in support of community mental health centers.[9]

With ATD, psychiatric patients and mental health professionals acting on their behalf had access to federal grants-in-aid, supplemented by state funds in some states, which enabled patients to support themselves or to be supported either at home or in such facilities as board-and-care homes or old hotels at comparatively little cost to the state. The amount of money available to patients under ATD was sufficient to maintain a low standard of living in the community. Thus the states, even those that provided generous ATD supplements, found that it cost far less to maintain patients in the community than in the hospital. (ATD is now included in Supplemental Security Income, or SSI, and is administered by the Social Security Administration.)

The second significant federal development of 1963 was the passage of the *Community Mental Health Centers Construction Act*, amended in 1965 to provide

grants for the initial costs of staffing the newly constructed centers. This legislation was a strong incentive to the development of community programs with the potential to treat people whose main resource previously had been the state hospital. It is important to note, however, that although rehabilitative services and precare and aftercare services were eligible for funding, an agency did not have to offer those services in order to qualify for funding as a comprehensive community mental health center.

Also contributing to deinstitutionalization were sweeping changes in the commitment laws of the various states. In California, for instance, the Lanterman-Petris-Short Act of 1968 provided further impetus for the movement of patients out of hospitals. Behind this legislation was a concern for the civil rights of the psychiatric patient, much of it from civil rights groups and individuals outside the mental health professions.[10] The act made the involuntary commitment of psychiatric patients a much more complex process, and it became difficult to hold psychiatric patients in mental hospitals indefinitely against their will.[11]

Some mental health professionals in California clearly recognized that while many abuses needed to be corrected this legislation went too far in the other direction and no longer safeguarded the welfare of the patient. But these were voices in the wilderness. We still have not found a way to help some mental health lawyers and patients' rights advocates see that they have contributed heavily to the problem of homelessness—that patients' rights to freedom are not synonymous with releasing them to the streets where they cannot take care of themselves, are too disorganized or fearful to avail themselves of what help is available, and are easy prey for every predator.

The dimensions of the phenomenon of deinstitutionalization are revealed by the numbers. In 1955, there were 559,000 patients in state hospitals in the United States; today, at any given time there are approximately 116,000.[12]

The Naivete of the Early Years

With the advantage of hindsight we can see that the era of deinstitutionalization was ushered in with much naivete and many simplistic notions as to what would become of the chronically and severely mentally ill. The importance of psychoactive medication and a stable source of financial support was perceived, but the importance of developing such fundamental resources as supportive living arrangements was often not clearly seen, or at least not implemented. "Community treatment" was much discussed, but there was no clear idea as to what this should consist of, nor was it anticipated how resistant the community mental health centers would be to providing services to the chronically mentally ill. Nor was it foreseen how reluctant many states would be to allocate funds for community based services.

In the midst of very valid concerns about the shortcomings and antitherapeutic aspects of state hospitals, it was not appreciated that those hospitals fulfilled some very crucial functions for the chronically and severely mentally ill. The term "asylum" was in many ways an appropriate one, for these imperfect institutions did provide asylum and sanctuary from the pressures of the world with which, in varying degrees, most of these patients were unable to cope.[13] Further, these institutions provided such services as medical care, patient monitoring, respite for the patient's family, and a social network for the patient, as well as food, shelter, and social support.[14]

The treatment and services in state hospitals were in one place and under one administration. The situation is very different in the community. Services and treatment are under various administrative jurisdictions and in various locations. Even the mentally healthy have difficulty dealing with a number of bureaucracies, both governmental and private, and getting their needs met. Furthermore, patients can easily get lost in the community as compared to a hospital where they may have been neglected, but at least their whereabouts were known. It is these problems that have led to the recognition of the importance of case management, which will be discussed further under recommendations. It is probable that many of the homeless mentally ill would not be on the streets if they were on the caseload of a professional or paraprofessional trained to deal with the problems of the chronically mentally ill, able to monitor them with considerable persistence when necessary, and facilitate services to them.

In my experience,[15] and that of others,[16] the survival of long-term patients, let alone their rehabilitation, begins with an appropriately supportive and structured living arrangement. Other treatment and rehabilitation are of little avail until patients feel secure and are stabilized in their living situation. Deinstitutionalization means granting support in the community to a large marginal population, many of whom, even with modern psychoactive medications and community treatment, can cope to only a limited extent with the ordinary demands of life, have strong dependency needs, and are not able to live independently.

Moreover, that some patients might need to reside in a long-term, locked, intensively supervised community facility was a foreign thought to most who advocated a return to the community in the early years of emptying the state hospitals. "Patients who need a secure environment can remain in the state hospital" was the rationale. But in those early years, most mental health professionals seemed to think

that such patients were few and that treatment in the community and the new psychoactive medications would take care of most problems. More people are now recognizing that many severely disabled patients present major problems in management. These persons can survive and basic needs can be met outside of state hospitals only if they have a sufficiently structured facility or other mechanism of providing controls in the community.[17] Some of the homeless appear to be from this group. A function of the old state hospitals that is often given too little weight is that of providing structure. Without this structure, many of the chronically mentally ill feel lost and cast adrift in the community, however much they may deny it.

Why Are They Homeless?

Why chronically and severely mentally ill persons are homeless is being explored in a research project in progress by the author in which homeless mentally ill persons were interviewed and, when possible, further information was obtained from their families. For the most part, the mentally ill are not homeless because they want to be, or because of a lack of housing or a lack of jobs. In Los Angeles, where this study was done, there are empty beds in the board and care homes and other facilities suitable for the chronically and severely mentally ill. There also was no shortage of jobs. However, it cannot be overemphasized that the great majority of these persons cannot manage living independently in mainstream housing, subsidized or otherwise. With regard to jobs, few of these persons are able to work.

At this stage of the research, in almost every case there are two primary reasons for these mentally ill persons being homeless: (1) they are not in contact with the mental health system or any other social agency that has responsibility for their care and for assisting them in meeting their needs—nor does the mental health system reach out to them in any systematic way; and (2) these mentally ill persons are too disorganized and have, as a result of their illness, insufficient problem-solving abilities to find and receive the help and resources that would enable them to find an alternative to the streets.

Obviously, there are many pathways to the streets, and I think it is useful to look briefly at some of them. The chronically and severely mentally ill are not proficient at coping with the stresses of this world. Therefore, they are vulnerable to eviction from their living arrangements, sometimes because of an inability to deal with difficult or even ordinary landlord-tenant situations and sometimes because of circumstances in which they play a leading role. In the absence of an adequate case management system, they are out on the streets and on their own. Many, especially the young, have a tendency to drift away from their families or from a board and care home;[18] they may be trying to escape the pull of dependency and may not be ready to come to terms with living in a sheltered, low-pressure environment. If they still have goals, they may find an inactive lifestyle extremely depressing. Or they may want more freedom to drink or to use street drugs. Some may regard leaving their comparatively static milieu as a necessary part of the process of realizing their goals, but this is a process that exacts its price in terms of homelessness, crises, exacerbations of illness, and hospitalizations. Once the mentally ill are out on their own, they will more than likely stop taking their medications and, after a while, lose touch with the Social Security Administration and will no longer be able to receive their Supplemental Security Income checks. Poor judgment and the state of disarray associated with their illness may cause them to fail to notify the Social Security Administration of a change of address or to fail to appear for a redetermination hearing. Their lack of medical care on the streets and the effects of alcohol and other drug abuse are further serious complications. They may now be too disorganized to extricate themselves from living on the streets—except by exhibiting blatantly bizarre or disruptive behavior that leads to their being taken to a hospital or jail.

The Use of Shelters in Perspective

There is currently much emphasis on providing emergency shelter to the homeless, and certainly this must be done. However, it is important to get this "shelter approach" into perspective; it is a necessary stopgap, but it does not address the basic causes of homelessness. As a matter of fact, too much emphasis on shelters can only delay our coming to grips with the underlying problems that result in homelessness. This must be kept in mind even as we sharpen our techniques for working with mentally ill persons who are already homeless.

Most mental health professionals are disinclined to treat "street people" or "transients."[19] Moreover, in the case of many of the homeless, we are working with persons whose lack of trust and desire for autonomy causes them not to give us their real names, not to accept our services, and not to stay in one place because of their fear of closeness or fear of losing their autonomy or because they do not want to be identified as mentally ill. Providing food and shelter with no strings attached, especially in a facility that has a close involvement with mental health professionals, a clear conception of the needs of the mentally ill, and the ready availability of other services, can be an opening wedge that will give us the opportunity to treat a few members of this population.

At the same time, we have learned that we must beware of simple solutions and recognize that the

shelter approach is nowhere near being a definitive solution to the basic problems of the homeless mentally ill. Providing emergency shelter does not substitute for the array of measures that would be effective in significantly reducing and preventing homelessness: a full range of residential placements; aggressive case management; changes in the legal system that would facilitate involuntary treatment; a stable source of income for each patient; access to acute hospitalization and other vitally needed community services.

Still another problem to the shelter approach is that many of the homeless mentally ill will accept shelter, but nothing more, and will eventually return to a wretched and dangerous life on the streets.

What was not foreseen in the midst of the early optimism about returning the mentally ill to the community and restoring and rehabilitating them so they could take their places in the mainstream of society was the actual fate to befall them. Certainly it was not anticipated that criminalization and homelessness would be the lot for many.

Asylum and Dependency

I would like to turn now to the concept of asylum, and to dependency. When we talk about the homeless mentally ill, we are of course talking primarily about the chronically mentally ill. These issues are crucial to understanding the needs of the chronically mentally ill.

Because the old state hospitals were called asylums, the word asylum took on a bad, almost sinister, connotation. Only in recent years has the word again become respectable. But the fact that the chronically mentally ill have been deinstitutionalized does not mean that they no longer need social support, protection, and relief from the pressures of life either periodically or continuously. In short, they need asylum and sanctuary in the community.

The disability of chronic mental illness includes social isolation, vocational inadequacy, and exaggerated dependency needs. While many can eventually attain high levels of social and vocational functioning, a sizable proportion of the chronically mentally ill find it difficult to meet even the simple demands of living. Many are unable to withstand pressure and are apt to develop incapacitating psychiatric symptoms when confronted with a common crisis of life. Programs can help patients develop social and vocational skills, but there are limits to what can be accomplished; inability to tolerate even minimal stress is a severely limiting characteristic.

For a number of the chronically mentally ill, too many demands—and for some any demands at all—will reactivate symptoms and perhaps necessitate a hospitalization. On the other hand, however, too few demands and too low expectations may result in regression.

Some mental health professionals consider it likely that many patients with chronic mental illness will lose their active symptoms more rapidly in a setting that is undemanding and permits them to limit involvement—in contrast to a setting that seeks to involve them in normal social intercourse and to move them toward even partial independence. The chronically mentally ill have a limited tolerance for stress, and avoidance of stress is one way of attempting to survive outside of the hospital. Medications and other community supports may also be required to ensure that patients are able to remain in the community.

Normalization of the patient's environment and rehabilitation to the greatest extent possible should be the goal of treatment. This environment should include the social milieu, the living situation, and the work situation. To the degree possible, the patient's condition should not be allowed to set him or her apart from other citizens in our society. This ideal of normalization (or mainstreaming), however, frequently cannot be achieved for a sizable proportion of chronically mentally ill persons. Every patient should be given every opportunity to reach normalization, but we need to realize that a number of our patients will fall short of it. If we persist in fruitless efforts to adjust people to a lifestyle beyond their ability, not only may we cause them anguish but we also run the risk of contributing to the emergence of manifest psychopathology. Moreover, we ourselves become frustrated and then angry at the patients. In the end we may reject them and find rationalizations to refer them elsewhere.

Many chronically mentally ill persons gravitate toward a lifestyle that will allow them to remain free from symptoms and unhappy feelings. This is not necessarily bad. But for some it may lead to unnecessary regression and serve as an impediment to increasing their level of social and vocational functioning; for those it should be discouraged. However, a case can be made that this restricted lifestyle meets the needs of many others and helps them maintain community tenure. Mental health professionals and society at large need to consider the crippling limitations of mental illness that do not yield to current treatment methods; they need to be unambivalent, moreover, about providing adequate care for this vulnerable group. For those who can be restored to only a limited degree, we should provide reasonable comfort and an undemanding life with dignity.

It is important that the moral disapproval of dependency in our society and unrealistic expectations for the severely disabled not prevent us from providing long-term patients with whatever degree of

treatment, support, and sanctuary they need to survive.

A major obstacle to understanding and addressing the problems of deinstitutionalization and the long-term patient has been a failure to recognize that there are many different kinds of long-term patients who vary greatly in their capacity for rehabilitation. Patients differ in ego strength (the ability to cope with stress) and in motivation. The severely disabled differ also in the kinds of stress and pressure they can handle. Some who are amenable to social rehabilitation cannot handle the stresses of vocational rehabilitation, and vice versa. What may appear to be, at first glance, a homogeneous group turns out to be a group that ranges from persons who can tolerate almost no stress at all to those who can, with some assistance, cope with most of life's demands. Thus, for some long-term patients, competitive employment, independent living, and a high level of social functioning are realistic goals; for others, just maintaining their present level of functioning should be considered a success. Recognizing patients' limitations as well as their strengths is one way of supporting and protecting them.

Likewise, in stressing a need for providing asylum, I want to avoid simplistic conceptions that suggest a homogeneous patient population. Consequently, asylum must mean different levels of social support and different types of protection for each patient. Simplistic notions that suggest a homogeneous patient population will repeat the same mistakes made so often with deinstitutionalization. In stressing the need for asylum and sanctuary, I am only stressing a principle that will have a different meaning, both qualitative and quantitative, for each patient.

There tends to be a basic moral disapproval in our society of a passive, inactive lifestyle, and of accepting public support instead of working. Such a moral reaction seems to occur in all of us. Although as a rule we try to deny our disapproval, our moral reaction confuses the issues and may interfere with the provision of appropriate care for the severely disabled. Our dissatisfaction with a primary role of gratifying chronic dependency needs and a more or less covert moral rejection of our patients' surrender to passivity are probably two impediments to our embracing the concept of asylum for the long-term mentally ill.

The Tendency to Drift

Drifter is a word that strikes a chord in all those who have contact with the chronically mentally ill—mental health professionals, families, and the patients. It is especially important to examine the phenomenon of drifting in the homeless mentally ill. The tendency is probably more pronounced in the young (ages 18 to 35), though it is by no means uncommon in the older age groups. Some drifters wander from community to community seeking a geographic solution to their problems; hoping to leave their problems behind, they find they have simply brought them to a new location. Others, who drift within one community, from one living situation to another, can best be described as drifting through life: They lead lives without goals, direction, or ties other than perhaps an intermittent hostile dependent relationship with relatives or other caretakers.[20]

Why do they drift? Apart from their desire to outrun their problems, their symptoms, and their failures, many have great difficulty achieving closeness and intimacy. A fantasy of finding closeness elsewhere encourages them to move on. Yet all too often, if they do stumble into an intimate relationship or find themselves in a residence where there is caring and closeness and sharing, the increased anxiety they experience creates a need to run.

They drift also in search of autonomy, as a way of denying their dependency and out of a desire for an isolated lifestyle. Lack of money often makes them unwelcome, and they may be evicted by family and friends. They also drift because of a reluctance to become involved in a mental health treatment program or a supportive out-of-home environment, such as a halfway house or board and care home, that would give them a mental patient identity and make them part of the mental health system: they do not want to see themselves as ill.

Gaining Their Liberty

Perhaps one of the brightest spots in looking at the effects of deinstitutionalization is that the mentally ill have gained a greatly increased measure of liberty. There is often a tendency to underestimate the value and humanizing effects of allowing former hospital patients simply to have liberty, to the extent that they can handle it, and of having free movement in the community. It is important to clarify that, even if these patients are unable to provide for their basic needs through employment or to live independently, these are separate issues from that of having one's freedom. Even if they live in mini-institutions in the community, such as board and care homes, these are not locked, and the patients generally have free access to community resources.

This issue needs to be qualified. As stated earlier, a small proportion of long-term, severely disabled psychiatric patients lack sufficient impulse control to handle living in an open setting, such as a board and care home or with relatives.[21] They need varying degrees of external structure and control to compensate for the inadequacy of their internal controls. They are usually reluctant to take psychotropic medications, and they often have problems with drugs and alcohol in addition to their mental illness. They tend not to remain in supportive

living situations, and often join the ranks of the homeless. The total number of such patients may not be great when compared to the total population of severely disabled patients. Though objective data are not available, I estimate that such patients constitute no more than a fifth of the chronically mentally ill. However, if placed in the community in living arrangements without sufficient structure, this group may require a large proportion of the time of mental health professionals, not to mention other agencies, such as the police. More important, they may be impulsively self-destructive or sometimes present a physical danger to others.

Furthermore, many members of this group refuse treatment services of any kind. For them, simple freedom can result in a life filled with intense anxiety, depression and deprivation, and often a chaotic life on the streets. Thus, they are frequently found among the homeless when not in hospitals and jails. These persons often need ongoing involuntary treatment, sometimes in 24-hour settings, such as California's locked skilled-nursing facilities with special programs for psychiatric patients[22] or, when more structure is needed, in hospitals. It should be emphasized that structure is more than just a locked door; other vital components are high staff-patient ratios and enough high-quality activities to structure most of the patient's day.

In my opinion, a large proportion of those in need of increased structure and control can be relocated from the streets and live in the community with family or in board and care homes, if they receive the assistance of such mechanisms as conservatorship (see Recommendations) as is provided in California. But even those with a structured situation in the community, such as conservatorship or guardianship, have varying degrees of freedom and an identity as persons in the community.

Criminalization

Community psychiatric resources, including hospital beds, are limited compared to the large numbers of mentally ill persons in the community. Society's limited tolerance for mentally disordered behavior results in pressure to institutionalize persons needing 24-hour care wherever there is room, including jail. Indeed, several studies describe a "criminalization" of mentally disordered behavior,[23] that is, a shunting of mentally ill persons in need of treatment into the criminal justice system instead of the mental health system. Rather than hospitalization and psychiatric treatment, the mentally ill often tend to be inappropriately arrested and incarcerated. Legal restrictions placed on involuntary hospitalization also probably result in a diversion of some patients to the criminal justice system.

Two studies of county jail inmates, one of 102 men and one of 101 women, referred for psychiatric evaluation,[24] shed some light on the issues of both criminalization and homelessness. This population has had extensive experience with both the criminal justice and mental health systems, is characterized by severe acute and chronic mental illness, and generally functions at a low level. Homelessness is frequent; 39 percent had been living, at the point of arrest, on the streets, on the beach, in missions, or in cheap, transient skid-row hotels. Clearly, the problems of homelessness and criminalization are interrelated.

Almost half of those men and women charged with misdemeanors had been living on the streets or on the beach or in missions or in cheap transient hotels, compared with a fourth of those charged with felonies (chi-square, $p = .01$). One can speculate on some possible explanations of this finding. Persons living in such places obviously have a minimum of community supports. It is possible that the less serious misdemeanor offense is frequently a way of asking for help. Still another factor may be that many members of this group of uncared-for mentally ill persons are being arrested for minor criminal acts that are really manifestations of their illness, their lack of treatment, and the lack of structure in their lives. Certainly, these were the clinical impressions of the investigators as they talked to these inmates and their families and read the police reports.

Recommendations

I believe that homelessness and criminalization among the mentally ill are symptoms of the basic underlying problems facing the chronically mentally ill in the community. Thus, to address the problems of the homeless mentally ill, a comprehensive and integrated system of care for the chronically mentally ill, with designated responsibility, with accountability, and with adequate fiscal resources, must be established.[25] More specifically, a number of steps need to be taken to achieve this comprehensive and integrated system of care.

1. *Community Housing.* An adequate number and ample range of graded, step-wise, supervised community housing settings should be established. While many of the homeless may benefit from temporary housing, such as shelters, and some small portion of the severely and chronically mentally ill can graduate to independent living, for the vast majority neither shelters nor mainstream low-cost housing is appropriate. Most housing settings that require people to manage by themselves are beyond the capabilities of the chronically mentally ill. Instead, there must be settings offering different levels of supervision, both more and less intensive, including quarter-way and halfway houses, board and care homes, satellite housing, and foster or family care.
2. *Mental Health Services.* Adequate, comprehensive, and accessible psychiatric and reha-

bilitative services should be available, and must be assertively provided through outreach services when necessary. First, there must be an adequate number of direct psychiatric services, including on the streets and in the shelters and jails when appropriate, that provide: outreach contact with the mentally ill in the community; psychiatric assessment and evaluation; crisis intervention, including hospitalization; individualized treatment plans; psychotropic medication and other somatic therapies; and psychosocial treatment. Staffing levels are key, for it has been shown that effective services, especially when dealing with an active, younger caseload, require a patient-to-staff ratio of no more than ten patients for each full-time staff member. Second, there must be an adequate number of rehabilitative services, providing socialization experiences, training in the skills of everyday living, and social rehabilitation. Third, both treatment and rehabilitative services should be provided assertively—for instance, by going out to patients' living settings if they do not or cannot come to a centralized program. And fourth, the difficulty of working with some of these patients must not be underestimated.

3. *Medical Services.* General medical assessment and care should be available. Since we know that the chronically mentally ill have considerably greater morbidity and mortality rates than their counterparts of the same age in the general population, and the homeless have even higher rates, the ready availability of general medical care is essential and critical.

4. *Crisis Services.* Crisis services , both in-patient and out-patient, should be available and accessible to both the chronically mentally ill homeless and the chronically mentally ill in general.

5. *Sanctuary.* Ongoing asylum and sanctuary in the form of highly structured 24-hour care should be available for that small proportion of the chronically mentally ill who do not respond to current methods of treatment and rehabilitation. Some patients, even with high-quality treatment and rehabilitation efforts, remain dangerous or gravely disabled. For these patients, there is a pressing need for ongoing asylum in long-term settings, whether in hospitals or in facilities such as California's locked skilled-nursing facilities that have special programs for the mentally ill.

6. *Case Management.* A system of responsibility for the chronically mentally ill living in the community should be established, with the goal of ensuring that ultimately each patient has one mental health professional or paraprofessional (a case manager) responsible for his or her care. In this case management system, each patient would have an advocate who would have the appropriate psychiatric and medical assessments carried out, would formulate, together with the patient, an individualized treatment and rehabilitation plan, including the proper pharmacotherapy, and would monitor the patient and assist him or her in receiving services. Clearly, the shift of psychiatric care from institutional to community settings does not in any way eliminate the need to continue the provision of comprehensive services to mentally ill persons. As a result, society should declare its responsibility for the mentally ill who are unable to meet their own needs; governments must designate organizations in each region or locale with core responsibility and accountability for the care of the chronically mentally ill living there; and the staff of these agencies must be assigned individual patients for whom they are responsible. The ultimate goal should be to ensure that every chronically mentally ill person has one person—such as a case manager—who is responsible for his or her treatment and care.

7. *Individualized Treatment.* It needs to be recognized that the chronically mentally ill are a highly heterogeneous population. Goals for each person should be individualized and realistic. Rehabilitation can help some of this population to achieve relatively high levels of functioning. But for those who can manage only a passive, inactive lifestyle, providing asylum in the community in the form of support and structure and gratifying dependency needs should be seen as important tasks for mental health professionals and society generally.

8. *Support for Family Care.* For the more than 50 percent of the chronically ill population living at home or for those with positive ongoing relationships with their families, programs and respite care should be provided to enhance the family's ability to provide a support system. Where the use of family systems is not feasible, the patient should be linked up with a formal community support system. In any case, the entire burden of deinstitutionalization must not be allowed to fall on families.

9. *Out-Patient Psychiatric Care.* Basic changes must be made in legal and administrative procedures to ensure continuing community care for the chronically mentally ill. In the 1960s and 1970s, more stringent commitment laws and patients' rights advocacy remedied some very serious abuses in public hospital care. At the same time, however, these changes neglected the right of patients to high-quality comprehensive outpatient care, as well as the rights of families and society. New laws and procedures should be developed to ensure provision of psychiatric care in the community—that is, to guarantee a right to treatment in the community.

   It should become easier to obtain conservatorship status for out-patients who are so gravely disabled and/or have such impaired judgment that they cannot care for themselves in the community without legally sanctioned supervision. In California, conservatorship provides continuous control and monitoring of patients who need social controls, while also providing adequate legal safeguards. Conservatorship is granted by the court for one-year renewable periods for patients found gravely disabled (that is, as a result of mental disorder, they are unable to provide for their basic needs for food, clothing, and shelter). Patients under conservatorship may be hospitalized when necessary, and for an indefinite period; their money may be managed when they cannot manage it themselves; and they may be compelled to live in a suitable community residential facility that meets their needs for care and structure.

   Involuntary commitment laws must be made more humane to permit prompt return to active in-patient treatment for patients when acute exacerbations of their illnesses make their lives in the community chaotic and unbearable. Involuntary treatment laws should be revised to allow the option of outpatient civil commitment; in states that already have provisions for such treatment, that mechanism should be more widely used. Finally, advocacy efforts should be focused on the availability of competent care in the community.

10. *General Social Services.* General social services should be provided. Besides the need for specialized social services, such as socialization experiences and training in the skills of everyday living, there is also a pressing need for generic social services. Such services include arranging for escort services to agencies and potential residential placements, help with applications to entitlement programs, and assistance in mobilizing the resources of the family.

11. *Coordination of Services.* A system of coordination among funding sources and implementation agencies must be established. Because the problems of the mentally ill homeless must be addressed by multiple public and private authorities, coordination, so lacking in the deinstitutionalization process, must become a primary goal. The ultimate objective must be a true system of care rather than a loose network of services, and an ease of communication among different types of agencies (for example, psychiatric, social, vocational, and housing) as well as all across the governmental matrix, from local through federal.

12. *Workers.* An adequate number of professionals and paraprofessionals should be trained for community care of the chronically mentally ill. Among the additional specially trained workers needed, four groups are particularly important for this population: psychiatrists who are skilled in, and interested in, working with the chronically mentally ill; outreach workers who can engage the homeless mentally ill on the streets; case managers, preferably with sufficient training to provide therapeutic interventions themselves; and conservators, to act for patients too disabled to make clinically and economically sound decisions.

13. *Research.* Research into the causes and treatment of both chronic mental illness and homelessness needs to be expanded. Further, more accurate epidemiological data need to be gathered and analyzed. For instance, estimates of the total number of homeless persons in the U.S. range from 250,000 to 3 million. Currently, the research findings or incidence of mental illness among homeless groups are also highly variable; these differences depend largely on such methodological issues as where the sample is taken, whether standardized scales or comparable criteria of illness are used, and theoretical biases. Better data, using recognized diagnostic criteria and gathered by trained mental health professionals, need to be acquired.

14. **Funding.** Finally, additional monies must be expended for long-term solutions for the chronically mentally ill. Adequate new funds and better use of existing ones are needed to finance the system of care we envision, which incorporates supervised living arrangements, assertive case management, and an array of other services. Legislation

and governmental agencies should make a substantial part of mental health monies categorical, that is available only for services for the chronically mentally ill. Frequently, mental health funds without such limitations are allocated according to local whims and politics, with the chronically mentally ill receiving a low priority. In addition, financial support from existing entitlement programs, such as Supplemental Security Income and Medicaid, must be ensured.

In summary, the solutions to the problems of the mentally ill homeless, and the chronically mentally ill generally, are as manifold as the problems these solutions seek to remedy. Above all, however, we must remember that homelessness among the mentally ill is a symptom of the basic underlying problems of the chronically mentally ill generally and of deinstitutionalization. It is only by addressing these underlying problems that we will have a significant and lasting effect on homelessness among the severely and chronically mentally ill. We cannot succeed by simply treating the symptoms; we must treat the disease that is causing the symptom.

Endnotes

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The Low-Income Housing Crisis and Its Impact on Homelessness

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The thesis of this paper is that the primary cause of homelessness in this country is the large and growing gap between the cost of decent housing and the amounts that very low-income people can afford to pay for housing. After adjusting for inflation, it is clear both that the number of low-income households is increasing and that the number of affordable units is rapidly decreasing. As a result, homelessness has been increasing rapidly and will continue to do so until enough affordable housing is made available.

Paradoxically, this country can still boast that its housing, by and large, is the best in the world. No other country houses so many people so well. This fact makes our failure to deal with the low-income housing crisis all the more dramatic.

Low-Income Housing Needs and Trends

The large and growing gap between the cost of unsubsidized housing and the income that is available to pay for it has been exacerbated, but not caused, by the housing policies of the Reagan administration. The underlying problem is so severe that there would have been a growing housing crisis even if there had been no cuts from low-income housing budgets since President Reagan took office.

While the number of subsidized low-income housing units doubled between 1975 and 1985—from about 2 million units to 4 million units—this did not compensate for the rising costs of housing, which led to the virtual disappearance of unsubsidized, affordable low-income units. As a result, the problem is far worse now than it was ten years ago.

Since 1970, gross rents[1] have been rising faster than the incomes of renter households. This has been true for all renters, not just low-income renters. In 1970, the median rent-income ratio for all renters was 20 percent of income; by 1976, it had risen to 24

Table 1

Housing Costs as Percent of Income, United States, 1983, by Income and Tenure

(households in thousands)

United States	Total	Less than $3,000	$3,000 to $6,999	$7,000 to $9,999	$10,000 to $14,999	$15,000 to $19,999	$20,000 to $24,999	$25,000 to $34,999	$35,000 or more
Mortgaged Owners									
Under 15%	10,447	2	1	3	56	177	509	2,208	7,493
15-24	11,717	8	11	80	497	1,109	1,561	3,759	4,694
25-34	6,104	11	45	228	835	1,038	1,026	1,614	1,309
35-59	3,903	17	392	541	966	717	473	488	312
60 or more	2,021	524	730	357	219	108	34	23	26
Total	34,192	561	1,180	1,208	2,573	3,148	3,602	8,091	13,835
Unmortgaged Owners									
Under 15%	11,836	18	199	474	1,588	1,824	1,644	2,583	3,506
15-24	4,212	16	829	1,088	1,301	554	261	131	30
25-34	1,739	23	811	480	331	72	14	7	3
35-59	1,274	109	844	252	53	11	0	3	3
60 or more	769	490	246	24	7	0	3	0	0
Total	19,830	656	2,929	2,318	3,280	2,461	1,922	2,724	3,541
Renters									
Under 15%	4,094	19	92	94	220	389	460	1,175	1,647
15-24	8,235	45	574	464	1,382	1,747	1,547	1,750	727
25-34	6,139	78	975	828	1,914	1,342	540	389	75
35-59	6,022	176	1,844	1,511	1,727	486	193	67	20
60 or more	5,425	1,991	2,688	479	210	44	7	7	0
Total	29,915	2,309	6,172	3,376	5,453	4,008	2,747	3,388	2,469
All Households									
Under 15%	26,378	39	292	571	1,864	2,389	2,613	5,966	12,646
15-24	24,164	69	1,414	1,632	3,180	3,410	3,369	5,639	5,451
25-34	13,982	112	1,830	1,536	3,079	2,452	1,580	2,009	1,387
35-59	11,199	302	3,079	2,304	2,746	1,214	666	558	335
60 or more	8,215	3,004	3,664	859	436	152	44	30	26
Total	83,938	3,527	10,281	6,902	11,305	9,618	8,271	14,203	19,845

Source: U.S. Department of Commerce, U.S. Bureau of the Census, *Current Housing Reports*, Series H-150-83, *Financial Characteristics of the Inventory for the United States and Regions: 1983*, Annual Housing Survey, 1983, Part C, Table A-1 (AHS figures adjusted for unreported units).

percent; by 1980, to 27 percent; and by 1983, to 29 percent. By 1990, median gross rents could easily reach 35 percent of median renter income.[2]

There has also been a gradual upward trend in costs for owners. The median cost-income ratio for owners with mortgages rose from 18 percent of income in 1976 to 20 percent in 1983, while the median for owners without mortgages rose from 11 percent to 13 percent of income.[3] By 1990, at this rate of increase, median cost-income ratios will reach 22 percent for owners with mortgages and 15 percent for those without them.

Medians are useful primarily as a broad indicator of trends. In fact, the vast majority of low-income renters pay far more than the median percentage of income for shelter, while more affluent renters pay less.

In 1983, the latest year for which comprehensive data are available, median renter household income was $12,800. The median gross rent-income ratio was 29 percent of income. But 5.4 million renter households (18 percent of all renter households) paid more than 60 percent of their incomes for rent and utilities, and 95 percent of these households had incomes under $15,000 per year. At the bottom of the income scale, 86 percent of the 2 million renter households with incomes under $3,000 paid more than 60 percent of their incomes for gross rent. In contrast, two thirds of the 1.6 million renter households with incomes above $35,000 paid less than 15 percent of their incomes for gross rent, and 90 percent of all renters who paid less than 15 percent of their incomes for rent had incomes above $15,000.

While a majority of the households in 1983 with very high shelter costs in relation to their incomes were renters, there were 2.0 million owners with mortgages and another 0.8 million owners without mortgages who paid over 60 percent of their incomes for housing. The vast majority of these households (80 percent of owners with mortgages and 99 percent of owners without mortgages) also had incomes below $10,000. (See Tables 1 & 2.)

Measures of Housing Affordability

It has been customary in housing to use a percentage of income as the affordability standard. This approach—though often the most practicable because of limitations in available data—has serious shortcomings. A large family, for example, must spend more for food and other needs than a single individual, and the modest adjustments made to income before calculating the 30 percent are not adequate to reflect these differences. Assuming that the concept of housing affordability is that housing should not cost so much that people are unable to obtain other basic necessities would lead to the conclusion that millionaires could pay well over 90 percent of their incomes for housing. Yet, the proportion of income spent for housing drops sharply as income increases.

The "Market Basket" Approach

A better way of measuring housing affordability would be a "market basket" or "residual" approach. This approach subtracts the cost of basic necessities, such as food, clothing, transportation, and health care, from income, and the remainder is the amount

Table 2

Housing Costs as Percent of Income, United States, 1983, by Income and Tenure, Percent of Households in Income Class

United States	Total	Less than $3,000	$3,000 to $6,999	$7,000 to $9,999	$10,000 to $14,999	$15,000 to $19,999	$20,000 to $24,999	$25,000 to $34,999	$35,000 or more
Mortgaged Owners									
Under 15%	30.6	0.3	0.1	0.2	2.2	5.6	14.1	27.3	54.2
15-24	34.3	1.3	1.0	6.6	19.3	35.2	43.3	46.5	33.9
25-34	17.9	2.0	3.8	18.9	32.5	33.0	28.5	19.9	9.5
35-59	11.4	3.0	33.2	44.8	37.5	22.8	13.1	6.0	2.3
60 or more	5.9	93.3	61.9	29.5	8.5	3.4	0.9	0.3	0.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Unmortgaged Owners									
Under 15%	59.7	2.7	6.8	20.5	48.4	74.1	85.5	94.8	99.0
15-24	21.2	2.5	28.3	47.0	39.7	22.5	13.6	4.8	0.8
25-34	8.8	3.5	27.7	20.7	10.1	2.9	0.7	0.3	0.1
35-59	6.4	16.6	28.8	10.9	1.6	0.5	0.0	0.1	0.1
60 or more	3.9	74.7	8.4	1.0	0.2	0.0	0.1	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Renters									
Under 15%	13.7	0.8	1.5	2.8	4.0	9.7	16.7	34.7	66.7
15-24	27.5	2.0	9.3	13.8	25.4	43.6	56.3	51.6	29.4
25-34	20.5	3.4	15.8	24.5	35.1	33.5	19.7	11.5	3.0
35-59	20.1	7.6	29.9	44.8	31.7	12.1	7.0	2.0	0.8
60 or more	18.1	86.2	43.5	14.2	3.9	1.1	0.3	0.2	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
All Households									
Under 15%	31.4	1.1	2.8	8.3	16.5	24.8	31.6	42.0	63.7
15-24	28.8	2.0	13.8	23.7	28.1	35.5	40.7	39.7	27.5
25-34	16.7	3.2	17.8	22.3	27.2	25.5	19.1	14.1	7.0
35-59	13.3	8.6	30.0	33.4	24.3	12.6	8.1	3.9	1.7
60 or more	9.8	85.2	35.6	12.4	3.9	1.6	0.5	0.2	0.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: U.S. Department of Commerce, U.S. Bureau of the Census, *Current Housing Reports*, Series H-150-83, *Financial Characteristics of the Inventory for the United States and Regions: 1983, Annual Housing Survey, 1983*, Part C, Table A-1 (AHS figures adjusted for unreported units

affordable for housing. The federal Bureau of Labor Statistics (BLS) used to publish a series of "urban family budgets" for a family of four, with adjustments for other household types. The last such budget was published in 1977. A rough measure of the cost of nonhousing needs for various household types can be estimated by using the 1977 Bureau of Labor Statistics "lower budget" adjusted by the change in the consumer price index since then.[4]

Using this approach, Table 3 shows the income levels that would be currently required for a number of household types before each household could "afford" to pay anything for housing.

In 1985, roughly one household in ten had an income below these levels. A preliminary analysis of the 1985 Census Bureau survey of household income indicates that about 9.9 million of the nation's 88.5 million households could not afford to pay anything for housing and still meet their other basic needs. (See Table 4.)

Shelter Cost as a Percentage of Income

The "market-basket" approach puts in perspective the current 30 percent of income rule of thumb for gross housing costs (that is, including utilities). People without enough income to cover their essential nonhousing expenses clearly cannot afford 30 percent of their incomes for shelter. However, the 30 percent of income standard cannot be entirely ignored because it is the current payment standard for housing assistance, and because HUD and others use it to measure "cost burden."[5] Applying this standard to people with very low incomes demonstrates both that 30 percent provides far too little to enable people to cover the costs of providing decent housing and that even if affordable housing were available it would be difficult to meet other needs. Table 5 shows the limited amount available under this standard for rent or mortgage payment, plus utilities and, for homeowners, insurance, maintenance and taxes.

Table 3

Estimated Annual Income Needed for Nonhousing Consumption at a Modest Living Standard, 1987

Household Type	Nonhousing Needs Annual	Monthly
Single person, under 35	$4,620	$385
Husband-wife, under 35		
No children	6,466	539
1 child, under 6	8,129	682
2 children, both under 6	9,500	792
Husband-wife, 35-54		
1 child, 6-15	10,827	902
2 children, older 6-15	13,201	1,100
3 children, oldest 6-15	15,310	1,276
Single person, 65 or over	3,690	308
Husband-wife, both over 65	6,725	560

Source: Calculated by the author from 1977 data published by the U.S. Bureau of Labor Statistics.

Table 4

Estimated Households with Incomes below Level Needed to Cover Consumption Needs Other Than Housing, Based on BLS Lower Living Standard Adjusted for Inflation, 1985

(households in thousands)

Average Needed	Threshold Level	Households below It
One Person	$3,828	2,870
Two Persons	5,956	1,906
Three Persons	8,759	1,692
Four Persons	10,456	1,451
Five Persons	14,104	1,041
Six Persons	17,752	463
Seven or More Persons	21,399	466
Total		9,888
All Households		88,458
Below Threshold as Percent of All Households		11.2%

Note: Thresholds for 6 and 7 persons estimated by adding incremental amount per person ($3648) between 4 and 5 persons

Source: U.S. Bureau of the Census, Current Population Reports, Series P-60, No. 156, *Money Income of Households, Families, and Persons in the United States, 1985*, U.S. Government Printing Office, Washington DC, 1987. Table 7. Straight-line distribution within intervals assumed to make estimates.

Comparison of Approaches

An analysis of 1983 Annual Housing Survey data by Michael Stone of the University of Massachusetts contrasts the market basket and percentage of income approaches. Stone found that in 1983 some 13.2 million renters were unable to pay for other necessities after paying gross rent,[6] compared to 16.1 million households who paid more than 25 percent of their income for rent and utilities. Although fewer households were shelter poor, their needs were greater than those of households with excessive rent income ratios. Stone estimated the average per-household affordability gap at $219 per month for shelter-poor households, compared to only $152 per month for those paying more than 25 percent of their incomes for rent. The aggregate affordability gap[7] was estimated at $35.4 billion under the market

Table 5

Amount Affordable for Gross Housing Costs at 30 Percent of Income, Selected Income Levels, 1985

Annual Income	Total	Monthly Income 30%	Remainder
$5,000	$417	$125	$292
10,000	833	250	583
15,000	1,250	375	875
20,000	1,667	500	1,167
25,000	2,083	625	1,458
35,000	2,917	875	2,042

Source: Calculated by the author.

basket approach and $28.0 billion under the percentage of income approach. Shelter poor households tended to be much larger: almost half (48.8 percent) had three or more persons, whereas only 36.2 percent of those paying over 25 percent of income were this large.

Relative Income: 50 Percent or 80 Percent of Median

Housing programs have also used relative income standards to determine eligibility for housing assistance. In 1974, federal law defined households with incomes below 50 percent of median, adjusted for household size, as "very low-income." "Lower income" households were defined as having incomes below 80 percent of median. However, the great disparity in income between renters and owners means that a substantial proportion of renters have incomes below these levels. In 1983, an estimated two-thirds of all renter households had incomes falling below 80 percent of median as defined by HUD and almost half (45 percent) of all renters fell below the 50 percent-of-median level. Conversely, not quite one-quarter of all renters had incomes above median as defined by HUD.[8]

These facts are often overlooked in discussions of the appropriate targeting of rental housing assistance, where cost considerations and lack of funds for subsidies provide an incentive to adopt fairly high income limits, such as median or 110 percent or 120 percent of median—levels which include the vast majority of renter households.

The Decline of Affordable Housing

Except for subsidized housing, affordable housing for very poor households (incomes under $5,000) is disappearing. In 1970, there were almost two housing units renting for less than $125 per month for every renter household with an income below $5,000. By 1983, this ratio was reversed: there were two extremely poor households for each unit. Primarily because of rising housing and utility costs, the number of units renting at $125 per month or less dropped from 14.9 million to 2.0 million between 1970 and 1983, while the number of renter households with incomes below $5,000 dropped from 8.4 to 5.5 million. In other words, low-income units disappeared from the inventory at the rate of one million a year, while the number of households with incomes below $5,000 diminished by only one quarter that rate. (See Table 6.)

The picture looks somewhat different when calculated in constant dollars (adjusted for inflation). As Table 7 shows, in 1983 constant dollars, the number of households with incomes below $5,000 increased at about the same rate that the number of units renting for less than $125 declined. Overall, the situation worsened at the rate of 250,000 units annually: the number of households with incomes under $5,000 grew by 125,000 units annually, while the number of units renting for less than $125 dropped by the same amount.

Projecting these trends indicates that there were 6 million extremely poor renter households in 1987, but only 3 million units at rents that are 30 percent of their incomes, and by 1995, if the trend continues, there will be 7 million renter households with incomes below $5,000 (in 1983 dollars), but only 2 million units renting at $125 or less.

The shortage of affordable housing at the very bottom of the income scale is reflected at somewhat higher income levels. The housing gap for people with incomes below $10,000 is also wide and growing, although the number of households is increasing less rapidly and the decline in affordable units is slightly slower at this income level. The 1983 gap was 1.5 million: 11.9 million renter households with incomes below $10,000 and 10.4 million units renting for $250 or less. The 1987 gap is estimated at 3.8 million units, and the 1995 gap at 5.6 million units.

Table 6

Extremely Poor Renter Households and Units Renting at 30 Percent of Income, 1970, 1980, and 1983
(current dollars)

	1970	1980	1983
Household Income under $5,000	8.4	6.3	5.5
Monthly Gross Rent under $125	14.9	2.7	2.0
Surplus/Deficit	+6.5	-3.6	-3.5

Source: Calculated by the author from U.S. Bureau of the Census, Annual Housing Surveys, 1980 and 1983.

Table 7

Changes in Renter Households and Affordable Rental Units, 1970-83, in 1983 Constant Dollars
(in thousands)

Category	Annual Household Income: Under $5,000	$5,000 to $9,999	$10,000 to $14,999	$15,000 or more	Total
1970 Renters					
Households	3,898	4,427	3,673	11,570	23,568
Units[1]	5,094	6,248	7,403	4,815	23,568
Gap/Surplus[2]	1,204	1,821	3,731	-6,755	0
1983 Renters					
Households	5,537	6,319	5,453	12,607	29,914
Units	3,498	6,899	9,874	9,643	29,914
Gap/Surplus	-2,039	580	4,421	-2,964	0
Change, 1970-83					
Households	1,647	1,893	1,780	1,037	6,354
Units	-1,596	652	2,471	4,827	6,354
Gap/Surplus[3]	-3,243	-1,241	690	3,791	0
Percent Change, 1970-83					
Households	42.3%	42.8%	48.5%	9.0%	27.0%
Units	-31.3%	10.4%	33.4%	100.2%	27.0%
Average Annual Change					
Households	127	146	137	80	489
Units	-123	50	190	371	489
Gap/Surplus	-249	-95	53	292	0

[1]Units with gross rent at 30 percent of income range.

[2]Number of units minus the number of households. Note that this figure grossly understates need for low-income housing, as it ignores such key factors as quality and availability, and the fact that many higher income households occupy low-rent units.

[3]Change in units less change in households.

Source: Estimated by author from data in *Annual Housing Survey, 1983*, Part A, General Characteristics of the Inventory, Table A-2.

Simply comparing the number of households and affordable units in the housing stock omits consideration of the fundamental questions of housing quality, size, location, and availability. Thus, if anything, the foregoing analysis has understated the housing problems faced by low-income households.

The Role of Subsidized Housing

Although most discussions of low-income housing focus on the subsidized housing stock, it is the private for-profit sector that provides the bulk of low-rent housing in this country, without housing subsidies. Only a small proportion of low-income households live in subsidized housing. Conversely, except for units with gross rents below $150 per month, only a small fraction of low-rent units are subsidized. Unless income can cover costs and provide a return to the owner, it cannot be profitable. So millions of low-rent units have been lost, primarily through rent increases as energy and other costs have risen. Expansion of the subsidized housing stock has been insufficient to offset this trend, even under the relatively high housing assistance levels of the Ford and Carter administrations.

The urgent need for additional low-income housing assistance was acknowledged in 1982 by a special commission appointed by President Reagan in 1981 to study the nation's housing problems and recommend solutions to them. This commission found that in 1980 there were about 20 million households with incomes below 50 percent of median. Half were renters. One quarter of these renters lived in subsidized housing. Almost all the rest were in substandard housing or unaffordable units, or both. Subtracting the 2.5 million households in subsidized housing from the 10 million renters leaves 7.5 million renter households needing assistance.

Table 8

Proportion of Households with Incomes below the Poverty Level Receiving Selected Federal Assistance, 1985-86

Housing	27.6% of poor renters
Food stamps	41.2% of all poor households
Medicaid	39.9% of all poor households
School Lunch	67.2% of poor households with children

Note: Data for income level and housing assistance are as of March 1986; data for other programs is for 1985.

Source: Data for income level and housing assistance are as of March 1986; data for other programs are for 1985. Source: U.S. Bureau of the Census, Current Population Reports, Consumer Income, Series P-60, No. 155, *Receipt of Selected Noncash Benefits, 1985*, U.S. Government Printing Office, Washington, DC, 1987. (Income and housing data as of March 1986.)

In other words, after more than 40 years of federal housing programs, for each very low-income household living in subsidized housing, there were three others who needed it, but who could not obtain it because it did not exist.

Unlike other "safety net" programs, under which assistance is provided as a matter of right to all applicants who meet eligibility standards, housing assistance for low-income people is not an entitlement. Households that apply and are eligible for assistance must wait until it becomes available. Even those who need housing aid urgently may have to wait years to obtain it.

This is a major reason why a large proportion of households with incomes below the poverty level live in unsubsidized housing. Since assistance is provided only in rental housing, owners are effectively excluded. As Table 8 shows, a far lower proportion of households with incomes below the poverty level receive housing assistance than receive other forms of basic federal assistance, such as Food Stamps and Medicaid.

The picture is even more stark when absolute income levels are examined. As Table 9 shows, fewer than one-quarter of the 1.3 million renter households with incomes below $2,500 annually live in assisted housing, an even lower proportion than those with incomes between $5,000 and $7,500.

Despite these figures, in 1983—the most recent year for which this information is available—subsidized housing accounted for 67 percent of all units renting for less than $100, 44 percent of all units between $100-149, and 21 percent of all units renting for $150-199 (as well as 11.5 percent of units renting between $200-249 and 8.3 percent between $250-299).

The federal government has provided low income housing assistance under a variety of programs since 1937. However, it was not until 1970 that the assisted housing inventory reached 1 million units. Since then, it has more than quadrupled. Until 1980, most federal housing subsidies were project-based, with the subsidy going to the owner of units rented to low-income households. After 1980, most of the increase in housing assistance has been through tenant-based subsidies, whereby recipient households receive a certificate or voucher and find their own units on the private market. Table 10 provides detail on annual increments in assisted housing, by program.

Expiring Use Restrictions and Subsidy Contracts

The slow but steady increase in the number of households receiving federal housing assistance is now, however, in jeopardy because use restrictions and subsidy contracts will expire at increasing rates.

Table 9

Number and Percent of Households in Subsidized Housing, by Income Level, 1986a

Household Income	All Households	All Renters	Subsidized Renters	Percent Subsidized	
				All	Renters
Under $2,500	2,150	1,272	295	13.7%	23.2%
$2,500-$4,999	4,634	2,919	1,022	22.1	35.0
$5,000-$7,499	6,017	3,346	1,017	16.9	30.4
$7,500-$9,999	4,980	2,486	443	8.9	17.8
$10,000 and over	70,677	22,027	1,023	1.4	4.6
Total	88,458	32,050	3,799	4.3	11.9

Source: U.S. Bureau of the Census, *Current Population Reports*, Consumer Income, Series P-60, No. 155, *Receipt of Selected Noncash Benefits, 1985*, U.S. Bureau of the Census, Washington, DC, 1987. (Income and housing data as of March 1986.)

Table 10

Estimated Annual Increase in Subsidized Housing Units, by Program, 1936-88

Calendar Year	Public Housing	Rent Supplement	Section 235	Section 236	Section 8	Cumulative Total
1936	798	0	0	0	0	798
1937	8,174	0	0	0	0	8,174
1938	21,639	0	0	0	0	21,639
1939	26,599	0	0	0	0	26,599
1940	60,917	0	0	0	0	60,917
1941	121,972	0	0	0	0	121,972
1942	158,144	0	0	0	0	158,144
1943	182,440	0	0	0	0	182,440
1944	185,709	0	0	0	0	185,709
1945	187,789	0	0	0	0	187,789
1946	189,714	0	0	0	0	189,714
1947	190,180	0	0	0	0	190,180
1948	191,528	0	0	0	0	191,528
1949	192,075	0	0	0	0	192,075
1950	193,330	0	0	0	0	193,330
1951	203,576	0	0	0	0	203,576
1952	261,834	0	0	0	0	261,834
1953	320,048	0	0	0	0	320,048
1954	364,341	0	0	0	0	364,341
1955	385,240	0	0	0	0	385,240
1956	397,233	0	0	0	0	397,233
1957	407,746	0	0	0	0	407,746
1958	423,218	0	0	0	0	423,218
1959	445,157	0	0	0	0	445,157
1960	461,558	0	0	0	0	461,558
1961	482,523	0	0	0	0	482,523
1962	511,205	0	0	0	0	511,205
1963	538,532	0	0	0	0	538,532
1964	563,020	0	0	0	0	563,020
1965	593,789	0	0	0	0	593,789
1966	624,614	0	0	0	0	624,614
Fiscal Year						
1966	652,355	0	0	0	0	652,355
1967	687,598	0	0	0	0	687,598
1968	740,692	790	0	0	0	741,482
1969	823,263	12,029	5,454	8,975	0	849,721
1970	903,462	28,034	65,838	17,187	0	1,014,521
1971	990,694	53,221	205,074	63,194	0	1,312,183
1972	1,064,828	68,409	344,955	156,139	0	1,634,331
1973	1,047,000	118,184	411,670	191,261	0	1,768,115
1974	1,109,000	147,847	418,905	293,831	0	1,969,583
1975	1,151,000	165,326	408,915	400,360	0	2,125,601
1976	1,167,000	177,645	339,325	439,872	130,471	2,254,313
1977	1,174,000	179,908	292,814	543,360	459,568	2,649,650
1978	1,173,000	171,598	261,866	544,515	666,603	2,817,582
1979	1,178,000	178,891	235,187	541,460	898,441	3,031,979
1980	1,192,000	164,992	219,482	538,285	1,153,311	3,431,070
1981	1,204,000	157,779	240,539	537,206	1,318,927	3,458,451
1982	1,224,000	153,355	241,927	536,531	1,526,683	3,682,496
1983	1,250,000	76,919	229,772	533,469	1,749,904	3,840,064
1984	1,331,908	55,646	209,730	530,735	1,909,812	4,037,791
1985	1,355,152	45,611	200,471	527,978	2,010,306	4,139,518
1986	1,379,679	34,376	182,268	529,121	2,143,339	4,268,783
1987	1,394,500	29,000	173,500	528,000	2,264,000	4,389,000
1988	1,399,600	29,000	163,000	527,000	2,374,600	4,493,200

Sources: 1935-1966: *Progress Report on Federal Housing Programs*, Committee Print, Subcommittee on Housing and Urban Affairs, Committee on Banking and Currency, U.S. Senate, May 9, 1967, Table H-3, p. 109. 1967-72: unpublished tables prepared by HUD budget office. 1973-88: tables on Units Eligible for Housing Payments from *HUD Budget Summary*, Fiscal Years 1975-88. Only totals from 1973 forward are adjusted for withdrawals from the assisted housing stock.

A condition of the provision of federal housing subsidies to for-profit owners has been their agreement to maintain the properties as low-income units for a specified period, generally 20 years.[9] In 1985 there were 1.9 million privately owned units with project-based federal assistance. Within 20 years, if no action is taken, this inventory could be reduced to one-tenth of its current size.[10] No one knows how many of these units will actually be lost, but one thing is clear: the more profitable conversion to high-rent units or condominiums, the more likely the owners are to exercise this option. This means that subsidized units in tight housing markets, with rapidly increasing rents (and concurrent increasing low-income housing needs) are where the problem will be most acute.

All housing subsidy contracts are for a specified period. The imminent expiration of these contracts presents a far greater threat than expiring use restrictions. Subsidy contracts for the Section 8 existing program have generally been for 15 years; those for vouchers are five years. Contracts to assist new or rehabilitated housing are generally for longer terms. The expiration of federal subsidy contracts will hit particularly hard beginning in 1991, when the first wave of 15-year Section 8 existing contracts comes up for renewal.

Trends in Federal Housing Assistance

There are three major categories of federal spending for housing: budget authority, or the total federal financial commitment over the life of the subsidy; outlays, or actual cash payments of these subsidies; and tax expenditures, or the cost to the Treasury of various special provisions of the Internal Revenue Code that provide exemptions, deductions, credits, or deferral of income for tax purposes (those regarding housing are referred to as housing-related tax expenditures).

There is a myth that for decades the federal government has poured major resources into massive low-income housing programs. The truth is that direct spending for housing assistance is dwarfed by housing-related tax expenditures. Outlays for federal housing assistance were less than 1 percent of the total federal budget until 1981 and have only once been more than 1.5 percent. Indeed, all federal spending for low-income housing payments plus public housing operating subsidies, from the beginning of the programs in the 1930s through fiscal year 1987, totaled $97 billion. This was $5 billion less than housing-related tax expenditures in 1986 and 1987 alone. In other words, the cost to the Treasury of special housing deductions, primarily homeowner mortgage interest and property taxes, was more in two years than the outlays for subsidized housing over 50 years.

Despite a series of cutbacks under the Carter administration from the level of additional assisted housing units provided under the Ford administration (which provided the highest annual number of subsidized units ever), over $30 billion in budget authority for HUD-subsidized low-income housing was appropriated by the Congress for fiscal 1981, when President Reagan took office. That was estimated to support an additional 250,000 low-rent units. Moreover, 55 percent were new or substantially rehabilitated units, thus adding to the nation's stock of needed rental housing.

Since 1981, there has been a dramatic decline in low-income housing assistance. Meanwhile, housing-related tax expenditures[11] more than doubled between 1980 and 1987. Table 12 compares annual low-income housing outlays and budget authority with housing-related tax expenditures.

Administration's Budget Request

The shift in federal housing assistance since 1980 from subsidizing units to subsidizing tenants is a shift from adding low-income stock to relying on the existing housing stock. In 1980, 81 percent of all HUD's incremental reservations were for new or rehabilitated units under programs that tied the subsidy to the unit. In 1987, only 35 percent of incremental reservations were for new or rehabilitated units; the remainder were for Section 8 existing certificates or vouchers, under which the recipient would find his or her own housing. Only 8 percent of the reservations proposed in the 1989 budget would be additions to the supply; the remainder are for tenant-based subsidies.

Inequities in Housing Subsidies

When federal housing subsidies are considered as a whole—including both direct subsidies and housing-related tax expenditures—it is clear that the pattern of federal housing assistance is regressive. That is, far more federal expenditures go to affluent people than to low-income people. This is largely because such a large proportion of federal housing assistance is provided through the tax code.

Data published by the congressional Joint Committee on Taxation indicate that 79 percent of housing-related tax expenditures in fiscal 1988 went to people in the top 27 percent of the income distribution.

Prior to the 1986 tax reform changes, roughly 10 percent of housing-related tax expenditures had been investor deductions, that, although they were taken primarily by those in the top tax brackets, did result in the construction, rehabilitation, or maintenance of lower income housing. However, even if these investor deductions are all allocated to low-income housing, the growing disparity between federal

Table 11

Units Provided and Federal Spending for Housing, 1980-89

Year	Units (thousands)			Federal Spending (billions)		
	HUD	Family Housing Assistance	Budget All	Authority[1]	Outlays[2]	Tax Expenditures[3]
1980	251	110	362	$27.9	$5.6	$26.5
1981	217	104	321	26.9[4]	7.8	33.3
1982	36	95	131	14.6	8.7	36.6
1983	-5	82	77	10.5	10.0	35.4
1984	75	77	152	12.7	11.3	37.9
1985	89	73	162	26.9[5]	25.3[6]	40.6
1986	83	54	137	11.6	12.4	48.5
1987	75	47	122	9.9	12.7	53.5
1988	88	53	141	10.5	13.8	53.7
1989[7]	108	29	137	9.6	14.8	52.6

Sources:

[1]Budget authority (authority to make spending commitment). Budget authority for housing programs is maximum cost over full term of subsidy contract. Source: Office of Management and Budget, *Historical Tables: Budget of the United States Government, 1989*, Table 5.1 and Table 3.3.

[2]Outlays are amount actually paid out during year for all units under subsidy.

[3]Tax expenditures are the cost to the Treasury of special housing-related provisions of the Internal Revenue Code. Office of Management and Budget, *Special Analyses: Budget of the United States Government: Fiscal Year 1989* (and prior years), Special Analysis G.

[4]This is amount after rescission requested by President Reagan. Initially, Congress appropriated $30.2 billion.

[5]Reflects one-time appropriation of $14.3 billion to forgive Treasury loans financing already constructed public housing. This change in financing resulted in some long-run savings to the Treasury, but no additional units.

[6]Reflects one-time outlay of $13.7 billion to redeem outstanding Treasury loans for already constructed public housing without permanent financing. (This was a change in financing method that produced no additional units.)

[7]1989 figures are levels proposed or projected in the Administration's budget request.

expenditures for middle and upper income households and those for low-income people is striking.

- In 1981, tax expenditures for middle and upper income housing totaled $31.5 billion, while budget authority and tax expenditures for low-income housing totaled $28.8 billion.
- This year (FY 1988), middle and upper income tax expenditures are estimated at $50.3 billion, while lower income housing tax expenditures and budget authority will total only $13.1 billion.

An analysis of 1988 household income data and housing expenditures, including tax expenditures, points up the great disparity between spending for high- and low-income people. The bottom fifth of all households received about 16 percent of all housing subsidies, while the top 27 percent got 62 percent of all subsidies. (See Table 13.) The average per household subsidy per month for households with incomes below $10,000 was $49, while the average monthly subsidy for households with incomes above $50,000 was $187 monthly.

Given the scope of low-income housing needs described above, it is critical to recognize the enormous costs of housing-related tax subsidies that go to people who clearly can afford decent housing without help.

Recommendations

Closing the Affordability Gap

If a major reason for homelessness is the inability to pay for housing, then a primary solution to the problem should be to make it possible for homeless persons to do so. Yet, except for the relatively small proportion of the stock that is subsidized and for an even smaller number of housing certificates or vouchers for use in the private sector, there are no programs to do this. Jonathan Kozol, in *Rachel and Her Children*, has written compellingly of the inadequacy of welfare officials to provide an adequate allowance to rent housing that is available, even while paying many times the required amount for "temporary" shelter in hotels. Moreover, the growing number of homeless people places continual strain on inadequate emergency shelters.

The capacity to pay the initial rent deposit, a continuing source of housing assistance through a rent certificate or voucher, and counseling and related assistance in the search for housing would, if available for all homeless households, enable them to make use of the housing resources in their communi-

Table 12

Estimated Household Income and Housing Subsidy Distribution, 1988
(households in thousands; subsidies in billions)

Annual Income	1986 Households		1988				
			Housing Tax Expenditures		Housing Outlays	Estimated Total	
	Number	Percent	Amount	Percent		Amount	Percent
Under $10,000	17,130	19.1%	$0.1	0.1%	$10.1	$10.1	15.7%
$10,000 to $20,000	19,157	21.4	1.1	2.2	2.7	3.8	5.9
$20,000 to $30,000	16,350	18.3	3.8	7.6	1.0	4.9	7.6
$30,000 to $40,000	13,167	14.7	5.4	10.7	0.0	5.4	8.4
$40,000 to $50,000	8,667	9.7	6.6	13.0	0.0	6.6	10.2
$50,000 and over	15,007	16.8	33.6	66.4	0.0	33.6	52.2
Total	89,479	100.0%	$50.6	100.0%	$13.8	$64.4	

Sources: Estimated by author based on several data sources. Household income based on data in U.S. Bureau of the Census, Current Population Reports, Series P-60, No. 157, *Money Income and Poverty Status of Families and Persons in the United States: 1986* (Advance Data from the March 1987 Current Population Survey), U.S. Bureau of the Census, Washington, DC 1987, Table 14, Selected Characteristics of Households, by Total Money Income in 1986. Housing subsidy distribution estimated from data in U.S. Bureau of the Census, Current Population Reports, Consumer Income, Series P-60, No. 155, *Receipt of Selected Noncash Benefits, 1985*, U.S. Bureau of the Census, Washington, DC, 1987, Table 14. Tax expenditure distribution estimated from data in Joint Committee on Taxation, *Estimates of Federal Tax Expenditures for Fiscal Years 1988-1992*, February 1987, Tables 2 and 3.

ties—housing that now is often underutilized or abandoned not because it isn't needed, but because those who need it cannot afford it.

Instead of rationing vouchers to fit within arbitrary budget and appropriation levels, they should be available on application to any household with an income below 50 percent of median who can demonstrate that they are homeless, facing the immediate threat of homelessness (e.g., subject to eviction or foreclosure), living in inadequate housing, or unable to afford other necessities after paying for rent and utilities.

Protect Presently Subsidized Housing

Fully half of the present stock of subsidized housing is threatened over the next two decades by loss of subsidy contracts, by default or foreclosure because rising costs have outstripped the subsidies provided, or by decisions of owners to opt out of low-income housing and convert their units to other uses. Furthermore, many older subsidized housing developments have not been adequately maintained, and need major repairs and renovation. This situation has come about primarily because past federal subsidy programs have not been designed or administered to pay for the full cost of providing decent housing for low-income people. Instead, as utility costs rose far more rapidly than tenant incomes during the 1970s, needed operating subsidies were either not provided at all or came too little and too late.

The nation cannot afford to lose any of this housing. If America makes it a principle that the units will not be lost, a combination that could save them would include additional subsidies, incentives to keep the housing subsidized, disincentives to convert (such as a windfall profits tax) or, if these fail, eminent domain acquisition by the public. In all but a few instances, it will be cheaper to retain the present subsidized housing than to replace it. Indeed, a study by the National Low Income Housing Preservation Commission found that the cost of retaining almost all of the assisted stock would be less than providing its residents with vouchers.[12] Moreover, where retaining such housing is more expensive, it is generally because of gentrification or other factors where retaining some low- and moderate-income housing is an important social objective.

Expiring subsidy contracts should be renewed or extended. Public and other subsidized housing that needs major repairs should be brought up to decent, viable standards. The total cost of doing this for a major portion of the assisted housing stock, the 700,000 units subsidized through the Section 236 and Section 221 programs, has been estimated by the National Low Income Housing Preservation Commission at $12 billion over the next 15 years.

Expanding the Supply of Affordable Housing

In the long run, the solution to the low-income housing problem lies in reducing the cost of housing to consumers. This can best be done by expanding the supply of low-rent housing through programs that would favor nonprofit housing developers and operators, those who see their task as providing decent housing at the lowest possible cost. Neighborhood-based community development corporations, tenant

cooperatives, churches and synagogues, labor unions and others are capable of playing a major role in providing decent, affordable housing, provided they receive the necessary capital and operating subsidies and technical assistance and support. Home ownership, with repayment of subsidies upon sale where possible, should also be vigorously supported. Such housing should be financed primarily by capital grants, to be repaid with interest only if and when the housing is converted to upper income or commercial use.

The Federal Role

Although there is increasing involvement of state and local governments in addressing housing needs, two basic roles for the federal government are critical. The first is to establish the economic and institutional framework within which the private sector provides and finances housing. Carrying out this role effectively can add to and improve the housing stock and expand the number of people who can afford it. The second major federal role, and the context for the foregoing recommendations, is to furnish the help necessary to enable people who cannot be served by the unassisted private sector to obtain decent housing.

The cost and income analysis presented above demonstrates that there is simply no way that the private sector, unaided, can meet the minimum housing needs of people whose incomes are below or near the poverty level. Indeed, utility and other operating costs have long been so high that a substantial number of poor households in this country find that these costs alone would be more than they can afford, even if their housing were provided free of charge. Moreover, the states and localities with the highest numbers of poor people are generally those least able to bear the substantial costs involved in providing access to decent, affordable housing. The solution to what has become a low-income housing crisis therefore requires far more in the way of federal funds than has previously been envisaged, even as the possibilities for administering housing assistance in partnership with state and local governments and the nonprofit sector are being pursued.

Endnotes

[1] Gross rents include actual or estimated cost of utilities and fuels.

[2] Calculated from *Annual Housing Survey* data, 1976, 1980 and 1983. The trend was projected to obtain the 1990 estimate.

[3] In the case of owners, shelter costs include taxes, insurance, utilities, fuel, garbage collection and, if mortgaged, the monthly mortgage payment.

[4] This is a higher standard than the poverty level (which is calculated by multiplying the estimated cost of a bare subsistence level food budget by three). BLS in the past has described its lower budget as providing a modest but adequate standard of living.

[5] The 30 percent standard is relatively new. The first subsidized housing efforts, in the 1930s, used 20 percent of income as the standard; this was later raised to 25 percent of income. The 30 percent level for all subsidized programs was enacted in 1981. In each case, the percentage deemed affordable was based more on the cost implications for housing subsidy and comparison with the cost burden for other renters than on any analysis of ability to pay.

[6] Michael E. Stone, "Shelter Poverty in the United States, 1970-83: Summary Figures and Tables," unpublished materials prepared for the Musgrove Housing Policy Conference, October 30-November 1, 1987.

[7] The amount necessary to cover the difference between what households could afford under the approach and actual rents (in other words, the amount that would be needed to subsidize the difference between what all renter households could afford and what they actually paid).

[8] Estimated from data in 1983 *Annual Housing Survey*, Part C, *Financial Characteristics of the Inventory*, Table A-1, applying HUD definitions to national data.

[9] In the early years of the Section 8 program, owners could "opt-out" at five-year intervals.

[10] General Accounting Office, *Rental Housing: Potential Reduction in the Privately Owned and Federally Assisted Inventory* (Washington, DC: June 1986). GAO estimates that the 1,890,000 units of privately owned, federally assisted housing that existed in FY 1985 will be reduced to between 174,000 and 842,000 units by 2005.

[11] Tax expenditures are the cost to the Treasury of special deductions or other provisions of the tax code. Major housing-related tax expenditures are homeowner deductions of mortgage interest and property taxes.

[12] National Low-Income Housing Preservation Commission, *Preventing the Disappearance of Low Income Housing* (Washington, DC: April 1988).

*Rethinking Housing with the Homeless in Mind**

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Intended and unintended plans and designs for the homeless can be divided into three categories: refuse, refuge, and community. Refuse places are minimum havens, at the exterior or perimeter area around and between buildings, on the streets and sidewalks. Refuge plans and designs are temporary alternatives to the street, primarily associated with formal organizations, such as churches, other nonprofit groups, and municipal, county, and state agencies. Refuge places range from emergency shelters to next stage or transition housing. Community plans and designs are low-income permanent housing and services with tenant involvement. Such plans and designs include tenant initiated and controlled limited equity cooperatives, neighborhood-based nonprofits, and large-scale public housing projects with tenant management. Community plans offer a variety of living arrangements that enable people to make adjustments to different demands during their life cycle and in response to changing lifestyles.

The categories refuse, refuge, and community are not the same as the frequently suggested three tiers of housing for the homeless: emergency, transition, and permanent. The three-tier housing division was a helpful concept when there was less sophistication about the varieties of homeless people, and when advocates in a number of cities

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were trying to respond quickly to growing problems by borrowing concepts from other places. What proved to be a useful conceptualization in the short run is less so now. Even then, the three-tier classification system was unsatisfactory because permanent housing did not always address the need to provide services other than shelter.

It is around the issue of social services in particular that homelessness has the potential to shift the debate about housing production to a more comprehensive concept of shelter-services, which would then be reflected in the built form. Social services as used here do not refer to the delivery of services by interchangeable workers in impersonal bureaucracies. Instead, it is an exchange of services that engages people in efforts leading to greater control over their living arrangements, social life, and access to economic resources. Housing policymakers do not agree about the union of housing and social services. The underlying issue pits those who emphasize using scarce resources to increase the supply of units against those who argue that housing by itself is an insufficient response to the needs of low-income people. Currently, the two sides agree that the homeless, a "special" part of the low-income population, need more than just shelter. As homeless and low-income housing advocates have coalesced around increasing the supply of low-income units, the services component threatens to be isolated as necessary only for particular segments of the homeless (e.g., those with mental illness, the chronically unemployed, families, young males aged 18 through 25).

This paper argues the shortsightedness of splitting services away from any shelter strategy. The paper sorts through the increasing array of terms in the homeless shelter and services vocabulary and illustrates how the terms refuse, refuge, and community are associated with particular building types and public spaces, and variations in the provision of services. Thereby, it uncovers conscious and unconscious values or preconceptions about home and family that arise with the provision of shelter and services.

The final sections of this paper link the issue about shelter and social services to the concept of community and the provision of low-income permanent housing. Drawing on the longer history of public housing and the recent history of homelessness, planning and design guidelines are offered for housing and services for the homeless and other "have not" groups. In conclusion, the paper suggests that some of these guidelines can be realized through state and federal legislation, some of which have already been passed.

Sorting through the Homeless Shelter and Service Language

Despite the severity of the affordable housing crisis, a positive outcome of the response to homelessness is a widening variety of creative housing and social service proposals and projects. The flood of ideas is reminiscent of the ferment that accompanied the promotion and passage of public housing in the 1930s. Table 1 reveals the large number of ideas that have emerged. The most common terms include: emergency shelters, transition housing, interim housing, permanent low-income housing, single room occupancy (SRO) hotels, apartment/residential hotels, and family centers. The terms are confusing and overlapping, mixing length of stay (from walk-in or drop-in centers for a part of the day to a person's lifetime), building structure (from single family houses to multiple dwelling units), building layout (relationship of public and private areas), building type (from independent units to congregate housing), degree of shared space (from individual to split facilities to group bathrooms, individual refrigerators to individual full kitchens and dining areas to common kitchen and dining areas, from independent apartments to shared apartments), degree of privacy (from barracks-like dormitories to individual rooms to apartments), types and levels of staffing (numbers, types of tasks, paid, resident participation, volunteers), tenure (free, fee payment, daily or weekly rates, monthly rental or limited equity cooperative), presence of social services (from crisis intervention to 24-hour care to follow-up care), and type of social services offered (child care, senior care, health care, counseling, referrals, English as a second language classes, job training, meals).

Victor Bach and Renee Steinhagen of the Community Service Society of New York suggest one topology based on function (entry and transitional shelters), physical configuration (congregate, apartment, and hotel shelters), and regulatory status (programs for meals, health care, other referral services). However, even this classification scheme fails to capture the problem in its entirety.

The variety of housing and social service possibilities often corresponds to the extent of dependency exhibited by the homeless, based on such considerations as mental illness, drug usage or abuse, disability, unemployment, or age (be it children or the elderly). The homeless are referred to in various ways, as clients, guests, refugees. On occasion, the shelter-service available is synonymous with what people are called. Thus, workers in public assistance agencies providing vouchers for welfare hotels speak of welfare clients, providers offering emergency shelters and transition housing favor usage of "guests," and members of politically oriented groups that regard themselves as providing sanctuaries refer to refugees.

Social Worth and Degrees of Control

Table 1 shows the great variety of shelter services, which share two common and interrelated

Table 1

Categories and Characteristics of Shelters and Services for the Homeless

	Emergency Shelters	Transition (also referred to as interim house/ hospice)	Permanent Low-Income Housing
De Facto SROs[1]			
Hotels	x	x	
Motels	x	x	
Intended SROs[2]		x	x
Apartment/Residential Hotels			x
Family Centers		x	x
Building Type			
Independent Units	x	x	x
Rooms	x	x	x
Barracks/Dormitory	x	x	
Congregate/ Group Home	x	x	x
Building Structure			
Single Family House	x	x	x
Duplex	x	x	x
Multiple Dwelling	x	x	x
Shared Space			
Bathroom	x	x	
Kitchen	x	x	
Bedrooms	possible/ for more than one unrelated person	with children and/or spouse	
Living Room	x	x	
Apartments		x	x
Building Layout			
No Access to Public[3]			x
Access to Public[3]			
Soup Kitchen	x		
Bathrooms	x		
Counseling	x	x	
Referrals	x	x	

	Emergency Shelters	Transition (also referred to as interim house/ hospice)	Permanent Low-Income Housing
Length of Stay			
Walk-In/or Drop-In	x	x	
Less 1 Month	x		
1-3 months	x		
3-6 Months	x	x	
6 Months-1 Year		x	
1-2 Years		x	
2 Years Plus		x	x
Staffing			
Paid	x	x	x
Volunteers	x	x	
Residents	x	x	
Tenure			
Free	x		
Fee Payment		x	x
Rental		x	x
Daily/Weekly			
Monthly			
Limited Equity Cooperatives			x
Rotation	x	x	
Available Social Services			
Crisis	x		
24 hour	x	x	x
Follow-up	x	x	
Type of Social Service[4]			
Child Care	x	x	x
Senior Care	x		x
Counseling	x	x	
Referrals	x	x	
English/ 2nd language	x	x	
Job Training	x	x	
Meals	x	x	

[1]Buildings originally intended for travelers, usually a room with bath.

[2]Buildings intended for long-term residents, originally provided with services such as housekeeping.

[3]"Public" refers to people off the street.

[4]Some low-income permanent housing offers a variety of services.

traits. The built form, as well as the spaces between buildings, reflects, first, how society evaluates the social worth of people and, second, the degree of social control society wants to impose on them. Buildings and open space around them, as well as entire areas, can be synonymous with a social type (e.g., consider mad-houses for mad people, lunatic asylums for lunacy). Skid Rows were thought of traditionally as areas where primarily older white alcoholic men were concentrated. With the increase in the numbers and types of people who are homeless, simplistic thinking about Skid Rows is changing. (This change is also being spurred by the redevelopment of inner city areas.) George Rand, for example, suggests the idea of "social development" or "social service" zones to describe settings like Skid Row that are characterized by commercial and public supports for the homeless—such as missions, food kitchens, day centers, and SROs.[1] Skid Rows may include both refuse and refuge places.

Refuse places, or minimum havens, reflect the most negative view about homeless people; these types of places are not under the purview of traditional housing and social service agencies, mainly, police, fire, public works, sanitation, and public health, all of which are engaged in "relocating" rather than "rehousing." Because homelessness is pervasive, agencies go outside their official mandates and cross jurisdictional lines. For example, a transportation agency like the bi-state Port Authority of New York and New Jersey is a reluctant but active partner in the shelter business. As New York City's Grand Central Railroad Terminal is restored to mark its 75th anniversary in 1988, the issue of its intended versus actual use is raised. Robert M. Hayes of the Coalition for the Homeless "estimated that 10 percent of the 400 to 500 people in the terminal have lived there for a year or more."[2] Peter E. Stangl, president of the Metro-North Commuter Railroad, leading the restoration effort, has stated that the terminal is a transportation facility, not a shelter. Time will tell if the aesthetic "look" will displace the refuse look.

Control over land uses is exerted primarily through zoning, which in turn reflects the status of people as inferred from the housing in which they live. Residential zones of single family houses are the most protected zones. Typically, multiple dwelling units are not found there, and single family homeowners are vigilant about changes in use that convert a single family house into a de facto multiple dwelling unit or group home. Zoning provisions for homeless facilities (or child care and housing for single parents, developmentally impaired persons, or AIDs victims) are revealing in what the immediate neighborhood may accept. The "Not In My Back Yard" or NIMBY syndrome reflects a threat to the ideal of permitting a built form that is unlike neighboring structures. If the form is not different—a greater likelihood if the shelter or service is located in a rehabilitated building—it is clearer that neighborhood objections are oriented to the perception that the people who will live in or use the facility, will be "different." Even then, certain groups among the homeless population may be more acceptable than others, e.g., women and children compared to young single men. This is similar to experiences about locating subsidized housing: facilities for the elderly are usually more welcome than for families, although there are instances where even the elderly are considered a threat.[3]

The Shelter Partnership of Los Angeles has written of the problems posed to "special populations" by local zoning and land use classifications and codes. They point out that there was little housing or services for homeless persons prior to the 1980s. As a result:

> Without a specific category, shelters were inappropriately classified as "guest houses," "hotels" or "dormitories." This meant that shelters were often difficult to site throughout the city because of their need for conditional use permits (CUPs) or zoning variances. Obtaining a CUP or a zoning variance for a hotel/dormitory/guest house was often enough to curtail or completely stall a much needed shelter project.[4]

Indeed, the Shelter Partnership helped draft changes in the Los Angeles municipal code, resulting in two national model ordinances for shelter siting.

The implicit model for emergency shelters and transition housing is a variation of the family, a new extended family that encourages resocialization. The language of independent living and self-sufficiency in a unit is similar to the description of developmental stages of children maturing and leaving the family nest. This is reinforced by facilities having designated levels of independence within one building, moving from dormitories to shared apartments to individual apartments. In several buildings, residents may move from emergency shelter to transition housing.

The idea of family organization is associated with living in a single family detached house. Some refuge facilities, indeed, are converted single family houses; others are duplexes and multiple dwelling units. The interiors of refuge places, whether new or rehabilitated, oftentimes use components associated with the house such as placing pediments over doors to rooms, putting mailboxes outside of individual rooms, designing floor coverings to simulate welcome doormats, and striving to furnish the facility as a home, with comfortable and attractive sofas, chairs, paintings, etc.[5]

An attempt to create a homelike and secure atmosphere may be found in the most unexpected places, including refuse places.[6]

Refuse Places

Refuse places, namely places that offer minimum havens for the homeless, are more extensive than simply the streets and sidewalks between and around buildings. Table 2 inventories the variety of places for makeshift shelters in alcoves, on or under benches, against walls. The building mass offers shade. Overhangs, porte cocheres, porches, and entrances may provide resting places with some protection from the weather. Heating grates are a particularly sought out spot. When access into a building is gained, it is likely to be a public or quasi-public institution, such as a city hall, museum, library, university building, or hospital emergency room, or parking structures, subways, and bus and train terminals. Parks, playgrounds, and public restrooms are other familiar venues.

One example of a formally established refuse/refuge place was the 1987 Los Angeles Urban Campground, a leftover space[7] on the grounds of the railroad adjacent to Skid Row, in a predominantly industrial downtown area. The term campground is deceiving. This was not a grassy area tended by park rangers, but a gravel and dirt surface that baked under the summer sun and was separated by a barbed wire and chain-link fence from other land uses. When traffic was not continuous from an overhead bridge located at one end, overhead lighting interfered with sleeping. The Urban Campground opened on June 15, was scheduled to close in August, and finally closed on September 25. An estimated 850 individuals, many of them homeless families, were at the camp in late August when people were no longer being admitted. Two mobile trailers were converted into bathroom facilities, and garden hoses provided running water; laundry was hung on the chain link fence that separated one part of the Urban Campground from the other. Each homeless person admitted to the Campground was searched before entering. Home consisted of cots under circus-like yellow and white striped canopies, the type usually found at street fairs or society galas. Organized homeless occupied three separate areas, with smaller groups in individual tents, many of whom personalized their front entrances with stones and pebbles picked up from the ground, donated flowers, and carpeting. This personalization is similar to what designers have in mind when they provide "homelike" touches in the form of pediments, mailboxes, and floor treatment as described earlier. The three areas took their names from their sponsors: Justiceville, the Union of the Homeless, and Love Camp. In Justiceville, for example, about 50 tents were located in a circle; homeless representatives described this as a conscious attempt to provide security for each other.

Nonetheless, it is difficult to generate enthusiasm about refuse places, or to think positively about them, in part because of the widespread ideal of the single family detached house with its white picket fence. The streets and sidewalks as home, regardless of whether a cardboard box offers some protection, is an image that Americans associate with developing nations. Homeless advocates in Los Angeles felt trapped into defending substandard conditions for people, first the right to sidewalk encampments quasi-organized by the homeless and then extending the life of the Urban Campground. Those defending refuse places include well-intentioned designers who suggest improved ways to live on the streets or in the camps. Donald McDonald, an architect in San Francisco, has designed a better constructed box—known locally as "city sleepers"—for use on the street. Design students at the University of Montreal invented ways to improve street furniture to accommodate needs of the homeless, such as placing surfaces around trees that can be used as standup food counters and providing hooks on fences for clothes. These types of suggestions are not confined to architects and designers. Leona L. Bachrach has commented on being present when health service delivery experts debated the relative merits of a

Table 2
Refuse Places, Minimum Havens

Exteriors of Buildings

alcoves	overhangs
benches with and without backs	porte cocheres
entrances and doorways	porches
	walls

Types of Buildings When Access is Gained

religious buildings	restrooms
city hall and other civic buildings	abandoned buildings
	department stores
museums	shopping malls
libraries	restaurants and bars
university buildings	parking structures
hospital emergency rooms	

Infrastructure and Open Space

parking structures	under viaducts, freeway overpasses
parking lots	
subways	grates
bus and train terminals	parks
	playgrounds
sidewalks	beaches
alleys	plazas
boardwalks	cliffs
sewer pipes	garden
grounds	

Vehicles or Related to

cars	garages
under cars	dumpsters
abandoned cars	surplus buses
subways	

Street Furniture

garbage cans	benches
bus stops	

Furniture in Buildings

movie theater seats	desks
church pews	counters
chairs	

Office Related

counters	chairs
floors	desks

Miscellaneous

shopping cart	clothes
backpack	

cardboard box, a reed hut, or an automobile as home, "particularly under benign climatic conditions such as those prevailing in southern California."[8]

Implicitly accepting street life is architect Victor Regnier's observations about day and night use of exterior spaces outside the Union Rescue Mission in Los Angeles. He described why he thought it necessary to soften or make more comfortable the urban edge where building meets the sidewalk.

> Men sit or stand outside, but no seating is available for them. There are no green trees or shrubs to soften a hard urban environment. . . . The building has no extensions, overhangs, or facade elements to shelter guests and neighborhood residents from rain, wind, or sun. Guests and other homeless persons loitering near the front also create special security problems.[9]

He recommended that the addition integrate the street uses and include: "Proper lighting, courtyard shapes that encourage self-surveillance, and screen separations that create 'semi-private' spaces [could] make the space more secure."[10]

The issue of home on the streets is further complicated because there are homeless people who prefer the street and its environs and argue persuasively that they are safer there, that the street offers more refuge than formal refuges. Inadequate as refuse places are, they represent a choice, albeit limited. This does not mean that smaller and better refuse places should be planned, designed, regulated, and controlled. At best, the informal strengths of the homeless need to be acknowledged where that is occurring, and integrated into plans and designs for refuge and community places.

Refuge Places

Refuge places are temporary alternatives to the street, on a continuum from emergency shelters to next stage housing. They may be an improvement on paper, although all too often a shambles in reality. The dilemma about sanctioning emergency shelters is reflected in the National Coalition of the Homeless' position that every person deserves decent, safe, and sanitary housing, attained by independent living in an apartment or house. One source of confusion about refuge places arises in distinguishing emergency shelters from transition housing, and distinguishing small- and large-scale refuge places.[11] Shelters are often thought of as barracks-like dormitories; "guests" in emergency shelters carry with them a greater stigma than those in transition housing. Nora R. Greer summarizes the characteristics of emergency shelters as follows:[12]

> People are accepted on a first come, first served basis, usually beginning in early evening.
>
> Some shelters provide lockers for guests' belongings.
>
> Most have adequate bathroom facilities.
>
> Most limit the number of nights a person is allowed to stay.
>
> Many serve at least one meal, which can range from sandwiches to a hot dinner.
>
> Few offer services beyond referrals.
>
> Most shelters range in size from 5 to 300 beds or larger.

Greer reports that the maximum desirable shelter size is 200 to 300, but she notes that service providers disagree about this.

Greer writes that many emergency shelters resemble concentration camps, and they are often associated with rigid and unexplainable rules. In a 47-bed shelter on the Lower East Side in New York City, for example, women must surrender all their money, have their bags inspected, answer questions without explanation, use the shampoo given to delouse themselves, obey the order to take a shower, and submit to a gynecological examination.

Greer qualifies transition housing by grouping it with special needs. She writes:

> Transitional housing most often provides shelter for three to six months or longer, to families or single men and women who are ready to move back into the mainstream of society, but who cannot find affordable housing. Accommodations range from dormitory living—the norm in emergency shelters—to private or shared apartments.
>
> Special needs housing is, as the name implies, for persons who are homeless due to special circumstances and who have special needs when homeless—youths aged 18 to 21, young mothers with children, abused women, the chronically mentally ill, among others. For these groups, emphasis is placed upon teaching each individual skills that will help that person lead a more independent life.[13]

Amy Rowland, after reviewing a variety of facilities, concludes that, "The only common denominator of transitional housing seems to be a length of stay which is longer than that allowed in emergency shelters."[14] While there are differences about minimum stay, at least three to six months, there is consensus that maximum stay ranges between one and two years.[15]

One of the overarching issues about refuge places concerns size.[16] In barracks-like dormitories, this is reflected in how much space is allocated between beds and how many beds comprise a module

within a larger unit. The question of size is also central to the design of SROs which can function as either emergency or transition or long-term, low-income, permanent housing. Although the family model still exists as an ideal in the vocabulary of SRO design, a hotel model is also present.[17] Indeed, in some cities, it has been openly stated that new or remodeled SROs can easily be converted into hotels for a tourist population as an area changes. Rowland believes that recommendations by the San Diego Mayor's Task Force on the Downtown Homeless are reminiscent of "cage hotels" found in some major cities during the first half of this century. The San Diego Mayor's Task Force on the Downtown Homeless suggests that a "personal habitat . . . short-term housing facility [should provide] each person with a small 5x8x4 foot lockable sleeping and storage space."[18] In January 1988, the San Diego "Living Unit Task Force" (empowered to recommend a formula for new and rehabilitated SROs to satisfy the California living unit law) proposed an SRO common space formula that allows for increases in common spaces as the size of rooms decreases.[19]

The Shelter Partnership of Los Angeles analyzed the operational characteristics of 13 shelters, ranging in size from six beds to 550, in Los Angeles County. Their most surprising finding was the little economies-of-scale.

> The survey results document that large shelters do not provide emergency services any less expensively than do small or medium-sized ones. Instead, the key determinants in unit cost appear to be the extent of services provided to clients by paid, professional staff and rent/mortgage expense.[20]

Model emergency shelters tend to be smaller, with homeless adults and children of the same family in individual rooms, but unrelated people may share the space because of demand. In part, small facilities reflect the breach created by lack of government support, a breach that religious institutions and socially aware individuals and organizations stepped into in response to homelessness. A local church, a retired businessman, nuns, a dedicated social worker, a rabbi are but a few examples of the profile of those who responded to homelessness in Los Angeles, fitting the homeless into religious or pre-existing buildings.

The House of Ruth, started as an emergency shelter, now provides transition housing as well. It is an example of a small-scale refuge,[21] established nine years ago by the Sisters of St. Joseph of Carondolet. Some money to run the House of Ruth comes from packaging different government grants and loans, but its funding strategy is heavily reliant on individual donations. The shelter is staffed by three coordinators who collectively run the emergency shelter. The paid staff includes part-time employees responsible for child care, counseling, and job training. The two-story house has a "homey" feel—guests eat and watch television in the old living and dining room; on the same floor senior aides supervise children who range in age from infants to five-year-olds. On its upper floor, the emergency shelter has four rooms for guests. Usually a woman and her children are in one room, but there are times when unrelated people share a room. A live-in staff member occupies a fifth room; three nights a week, another staff member sleeps in an alcove that also provides a secluded place for counseling. Staff also includes volunteers and interns; for example, nursing interns from a local hospital gave lectures to the staff on recognizing depression; in turn the nurses assisted the guests. In addition to a wide range of services when guests are either at the emergency shelter, or the newer transition housing—including assistance with various city agencies, e.g., schools, welfare—people are counseled about their skills and helped to find jobs. The staff holds classes to bring women's domestic skills to a professional level, ensuring that the women receive a fair wage and are not exploited or mistreated. Support does not stop when someone finds permanent housing; there are, for example, "rap" groups, invitations to meals at holidays, and child care.

Without any cost savings by size, whether emergency or transition, the planning and design issue becomes one of creating a feeling of home, and the administrative issue becomes one of recreating the most basic social unit, the family. The homeless, by definition, are not only "houseless," but "familyless," in the sense that they are no longer able to rely on a family or friends, other than those with a mate and children who are also homeless. In this light, it is not surprising that the Shelter Partnership found staff to be a key determinant of expenses. With labor intensive staffing, facilities begin to provide the types of support no longer available to the homeless by relatives. Out of this services mix emerges an alternative to the nuclear family, a model of a household that shares resources. The former homeless household, like other "have not" groups in society—such as battered women, drug dependents, and single parents—will continue to need social supports like "rap" groups, child care, and job counseling when they leave a refuge place. This need will range from being able to continue using services at the refuge, as at the House of Ruth, to drawing on other types of resources in the communities where they will find permanent affordable housing. The next section of this paper turns to the concept of community.

Community Places

The notion of community is often vague and abstract, but it usually includes the way people interact with each other in a particular place over a period of time. A sense of community may exist in a small refuge like the House of Ruth, in the refuse/refuge Urban Campground, and even on the streets, although intermittently. Different proposals in planning and architectural history define community by size of population, size of area, and types of facilities.[22] In many cases, the suggested size of population and types of facilities are the vehicles through which face-to-face relationships are encouraged in a particular area. The neighborhood unit, for example, refers to 5,000 households organized around an elementary school. There are theories about community with and without propinquity, the latter referring to social ties that may endure even with geographical separation. Studies of low-income people, however, point to the need for community with propinquity, with easy access to a range of facilities and services; this population does not have resources such as income and education that permit them freedom to move over a larger geographical network.[23]

Because of the commodity[24] nature of housing, people with resources choose housing in locations that give them access to a "bundle of services." As housing is the vehicle for creating home, neighborhood is the vehicle for creating community. The low-income person does not usually have access to privatized services, such as child, senior, and health care. There is a need in low-income communities for publicly sponsored services, including job training that may provide options to a higher standard of living. In this way, the community becomes a resource base.

Early proponents of public housing recognized the need for a variety of services in addition to shelter. Public housing reformers fought for an environment that was a refuge from the increasingly complex industrially based city. The idea of community in public projects included community facilities that were also a form of resocialization into mainstream society. This can be seen in the thinking of Beatrice G. Rosahn, who in the course of criticizing the lack of professional management training in the almost decade old public housing program, reiterated its supporters' original aims:

> most public housers, in advocating the expenditure of public funds for additional slum clearance developments, realistically continue to associate the movement with certain broad community purposes, such as the elimination of delinquency through constructive recreational outlets, development of better citizenship through adult education and community activities, higher standards of health and homemaking, etc.[25]

In arguing for integrating low-income people into the wider community, Rosahn revealed the need for more labor intensive efforts:

> The provision of good shelter alone does not necessarily lead to these related social benefits; constructive educational efforts are essential along with an improved physical environment, and it devolves upon management to assist, encourage, and stimulate tenant and integrated community activities. . . .[26]

As with the provision of facilities for the homeless, in order to go beyond the narrow concept of providing shelter, a labor intensive effort through management was needed.

The concepts of community in public housing and public housing as an instrument of social welfare were lost by the 1950s when Elizabeth Wood, former director of the Chicago Public Housing Authority (fired by Mayor Richard Daly because she opposed his administration's avowed segregation policy in public housing projects), stated that three choices faced public housing administrators. They could turn public housing into hospitals, treating the tenants as patients; they could act like the real estate operators they were proving to be, excluding problem families and evicting others; or they could restore the concept of community. By community, she referred to an income mix of tenants, allowing higher income tenants to put down roots and act as leadership role models for others in the community.

There were other controversies about providing more staff and facilities. The issues surrounding facilities concerned who should sponsor them—should they be absorbed into the public housing bureaucracy or provided through other public agencies—and what types of facilities should be provided and where, within individual units or the complex itself.

In 1950, writing under the pseudonym "Maxim Duplex," a member of the American Institute of Architects with a 20-year history in public and private residential development, published two articles on public housing design. Maxim found the nation's 172,000 public low-rent living units "fundamentally deficient."[27] They were too small, too institutional, "too paternalistic in character to measure up to any true native standard for a permanent home environment."[28] Although the housing provided was "sunny, sanitary, and safe—and composed of first-class construction materials—it still constitutes an intermediate . . . variety of shelter. . . . While being a long way from the slum in quality, it is not nearly close enough to the minimum adequate permanent home

to satisfy the normal requirements of family living."[29] Minimum standards had become maximum limits. Maxim deplored the result:

> the virtual elimination from the home of most of the normal recreational occupations of both children and parents. Minor carpentry, crafts, mechanical interests, and all other hobbies that require more than desk or table space, including the important category of home maintenance and repair activities, are unprovided for. Some of these occupations can take place at the community building but most of them disappear completely from the life of the publicly-subsidized tenant.[30]

Maxim was not just making a pitch for privatism and isolation in well-equipped units; he was suggesting an improved redistribution of individual and collective facilities. His suggestions for the unit were: more space for laundry, including indoor clothes drying, children's indoor play, adult hobbies in the unit, and private outdoor space that would permit mothers to supervise small children. For the collective, he stipulated: grounds area and buildings that the tenants could care for themselves, and the continuation of nursery schools, child clinics, meeting rooms and playgrounds. He suggested discontinuing central laundries and storage lockers. Maxim summarized his idea for a "community of individual homes," not based on detached housing but on the row house:

> We should design the house better, provide it with a private garden, and divest it of its institutional characteristics. We should eliminate from the project as many central operating functions and group services as feasible (*but with no arbitrary obstacles placed in the path of voluntary action by the tenants to provide for their group needs*) and rely primarily on the tenants, themselves, for all possible services of project upkeep and repair. We should make each dwelling a complete American home with no essentials omitted but with no extras added.[31] (emphasis added)

Maxim reminded readers that there were previous eras when the typical inexpensive American home included space for the types of activities he was suggesting, and that this could be encouraged again. In a statement that might be made of facilities for the homeless today, he wrote:

> To say that public dwellings should never exceed the quality of the lowest-priced units that private builders happen to be supplying at a particular place and time is to misunderstand both the objective in view and the proper means to its attainment. The minimum requirements of the American standard of living are observable realities. The inability of occasional housing producers to satisfy these requirements should not blind us to what those requirements actually are. Instead, we should define family living in a systematic way, divest them of Utopian tendencies, and allow them to influence the production of housing generally so that all types of families may live in adequate homes in as few years as possible.[32]

Since the 1960s, tenants in public housing have fought against public abandonment of their homes and have sought to restore community, thereby becoming empowered and controlling their environments. Women like Bertha Gilkey of Cochran Gardens in St. Louis and Kimi Gray of Parkside-Kenilworth in Washington, DC, have become national role models for tenant management. Tenant leaders in Los Angeles are beginning to demand that the housing authority be more accountable to resident needs. Inherent in tenants' redevelopment of public housing projects are adding back, or including for the first time, community facilities, neighborhood centers, health services, and child care, and redefining local community economic development in order to create meaningful jobs.

Community Planning and Design

What would a shelter-service option look like if ideas of community were pursued? Housing would be small scale, infill, fitting into an existing neighborhood,[33] with easy access to the outdoors, meeting places, and space that can be used for wage labor in "home-based" work. If this sounds suspiciously like old fashioned neighborhood or community planning, it is similar. It means being able to walk to facilities and stores, know people in the neighborhood, and live in an environment where there are informal and formal linkages to services. It includes what Bachrach infers in her continuity of care—a notion based in "post-World War II health planning, and properly realized, assures the provision of comprehensive, accessible, individualized and culturally relevant services over a long period of time and in a supportive and humane climate;"[34] Cecilia Henning's description of extended neighboring in Lambohov, a housing-social service complex in Linkoping, Sweden, where four families cared for a fifth who had either medical or social problems;[35] Hilda Ross' recommendations for the neighborhood family—a mutual aid project involving the elderly and non-elderly who act like a family within a specific physical setting; and what Jacqueline Leavitt and Susan Saegert see as the Community-Household—skills that exist in households, such as budgeting, resolving conflicts, maintaining social connections, that are

extended to reclaim landlord abandoned buildings and publicly abandoned low-income communities.

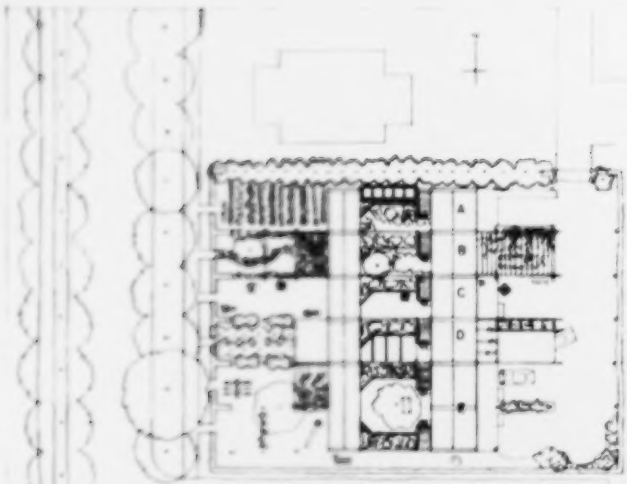
Neither the recent wave of gender related research nor the attention paid to small-scale organization for certain groups marks the first time that attention has been brought to these issues. In 1949, Hertha Kraus identified working mothers, large families, and older person families as having special housing needs. Her recommendations for the location of dwellings, such as accessibility to public transportation and employment, are relevant almost 40 years later. Because working mothers were often dependent on family aid, she suggested mutual aid where a dwelling would be shared by one or two other women with similar problems, combined into a composite household, or where an organized group would provide aid through neighborhood care facilities (for children of all ages, supervised playgrounds, infirmaries for the aged, infirm, and disabled). Kraus suggested changes in unit design and bureaucratic rules that would integrate and accommodate different types of households. Small housekeeping units could be planned as "a private annex of regular family homes in single family dwellings," and as floors or wings of multiple dwellings. "Composite family groups of two to three women and their dependents can become strongly self-sufficient in mutual aid." Kraus concluded by writing that more experimentation may be tried in competitions or the private market.

Although little response has occurred in the past 40 years, the results of one competition are promising. In 1984, the program for a national competition called for six prototypical units of urban infill housing, expressly for non-traditional households, on about a third of an acre site, each individual unit not to exceed 1,000 square feet, with a portion of the space exclusively dedicated to wage work.[36] The winning design by Troy West and myself crystallized around the shelter-service concept and was based on a row house of six contiguous buildings.[37] (Figure 1. Site Plan A to E) Each of the six units fronts the major street with its more public workplace side (workplace or work space refers to paid work). This siting was done purposely in order to promote community and casual neighboring in small ways; the idea was that as people pass by, a nodding acquaintance would develop.

In addition, the designers thought it was a good idea for children on the block to see that one option for paid work was to be closer to the place of residence instead of driving a car to a more distant workplace. The work spaces are places where people conduct business, for example, an artist's studio or lawyer's office, or they are adapted for a community service like a child care center. Figure 2 illustrates how movement from the street brings the person to the work space first; adjacent to it is a half-bathroom. The work space overlooks the inner court. This inner court may be handled in several ways, open or closed, with clear panes or solar panels. The work space is connected to the more private two-and-a-half-story residential zone by a one-story linear kitchen whose windows also overlook the inner court. The kitchen leads to the living room, which also has access to the court. Stairs in the living room lead to the second and third floor sleeping areas, full bathroom, and another half-bathroom. The main entrance to the residential space is from the rear alleyway. Carports are in the rear, along with access for the handicapped. The flipping of one end unit results in a double unit, labeled building E in the site plan. The flipping permits the last combined unit to become a single parent or intergenerational house with a center for children.[38] This unit has the flexibility of having either one or two kitchens; the ground floor residential area can be converted into an accessory unit, housing two single parents and an older person, or any combination thereof. The work space, now double the size, can become a child care space for the group of six buildings as well as for the block and neighborhood. The combined front yards can be a play area for the child care center; similarly the enlarged inside court can function this way.

The design and its original innovative components have changed as the project moved through the implementation stages in St. Paul, Minnesota. The site is larger, permitting 12 different houses with 14 units, in two groups of six houses that face each other across a mews. (Figure 3. Site Plan, Dayton Court) The units were never meant to be subsidized, but as changes were made ways were sought to bring down the selling price. This led to the creation of two additional units. The 14 units in four house types (two one-bedrooms; four two-bedrooms; six three-bedrooms; and two duplexes) include the creation of two one-story, one-bedroom units, each of which has a base selling price of approximately $37,500. Two other units have been subdivided to provide duplexes of 1,485 square feet at a selling price beginning at $109,000. This permits a number of options. A person with moderate income may rent the efficiency apartment of 310 square feet contained within each duplex; the owner of the duplex can realize income from this apartment, reducing his or her monthly housing costs. (Figure 4. Unit D, Duplex)

The winning design showed how two work spaces can be converted to child care, a pressing need for single parents. The design of the child care and work areas are equally suitable in facilities for the homeless, battered women, drug dependents, and others. The New American House can be seen as a kit of parts comprised of kitchen, court, residential area, and work area that can be converted to residential



SOME SITE OPTIONS

A AN ILLUSTRATOR OF CHILDREN'S STORIES LIVES WITH HER MAIDEN AUNT WHO IS AN AVID GARDENER AND ENERGY NUT. THEY CHOSE THE NORTH UNIT SO THEY COULD INSTALL A SOLAR COLLECTOR ON THE SPINE ROOF AND A CLEARSTORY WINDOW IN THE WORK SPACE.

B A LEGAL RESEARCH CONSULTANT HAS COVERED THE FRONT OF HIS WORK SPACE WITH A GRAPE ARBOR SO HE COULD HAVE MEETINGS OUTSIDE AND ALLOW HIS TWO SMALL CHILDREN TO PLAY UNDISTURBED IN THE PRIVATE OUTDOOR SPACE. THE CAR PORT HAS A TRANSITE ROOF COVERED WITH VINES.

C A COMMERCIAL ARTIST AND HIS TEENAGE SON, BOTH INTERESTED IN ART, HAVE COVERED THEIR PRIVATE OUTDOOR SPACE AND FRONT AND REAR YARDS WITH MARBLE CHIPS TO DISPLAY THEIR GROWING SCULPTURE COLLECTION.

D A SINGLE PARENT COMPUTER SCIENTIST, WHOSE BUSINESS HAS EXPANDED, HAS DOUBLED THE WORK AREA AND GLAZED THE PRIVATE OUTDOOR SPACE FOR A WINTERGARDEN. HER TWO CHILDREN HAVE GROWN TO NEED SEPARATE BEDROOMS. FIRST THE CARPORT BECAME A GARAGE AND NOW THE MUSICIAN SON HAS RENOVATED IT INTO A THIRD BEDROOM MUSIC CHAMBER.

E HERE TWO WORK UNITS ARE COMBINED TO FORM A DAY CARE CENTER. THE UNITS ARE FLIPPED TO CREATE A LARGE OUT DOOR PRIVATE SPACE. EACH DWELLING UNIT CAN BE AUTONOMOUS OR COMBINED AS CONGREGATE HOUSING FOR TWO SINGLE PARENTS AND UP TO FOUR CHILDREN AND A GRANNY FLAT IN THE LIVING ROOM OF THE SECOND UNIT.

SQ.FT. COMPUTATION OF FL. AREAS

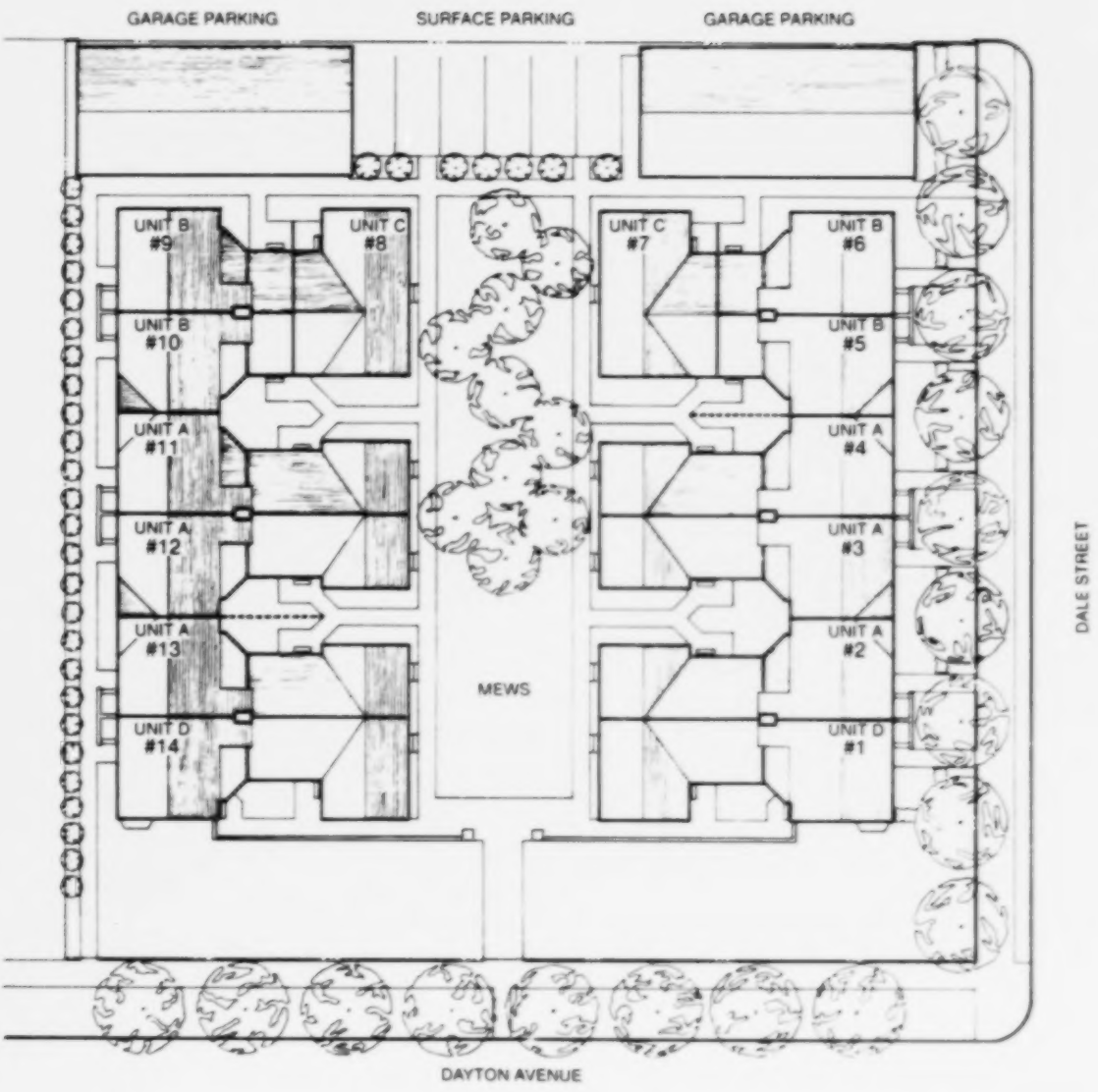
TOTAL [illegible] SQ.FT.

©

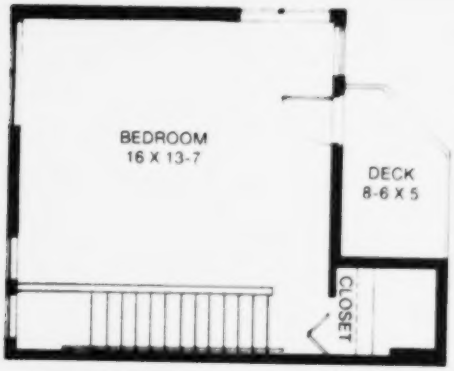
DAYTON COURT

North

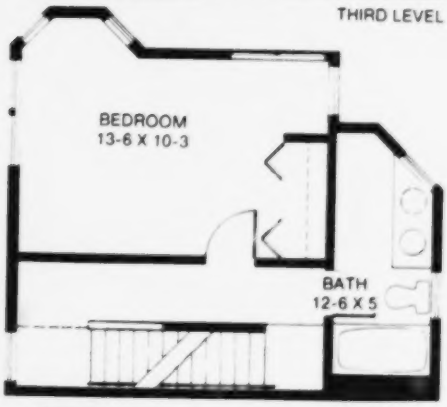
SITE PLAN



DAYTON COURT



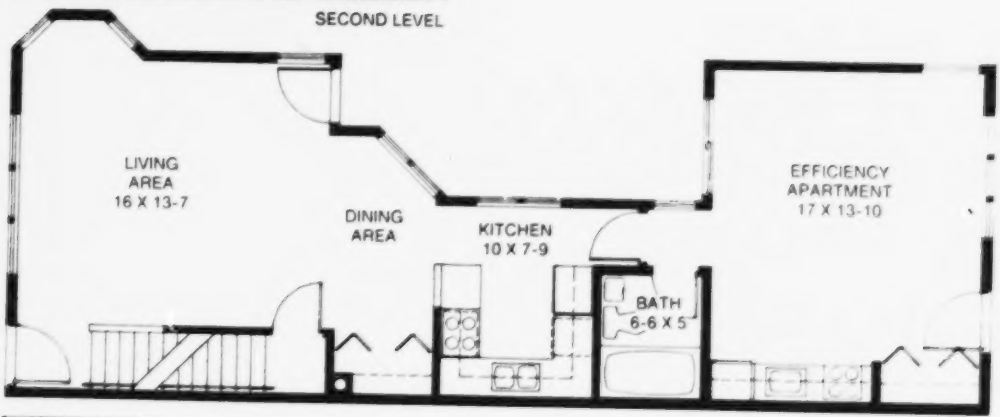
THIRD LEVEL



SECOND LEVEL

Unit D (Duplex)	Gross Area Sq. Ft.
Living Area	1485
Basement	246
Garage Space	

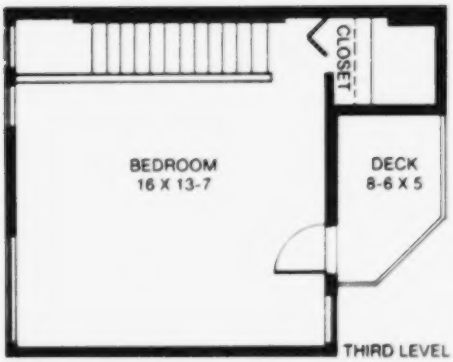
Dimensions and square footage are approximate. Actual construction may vary.

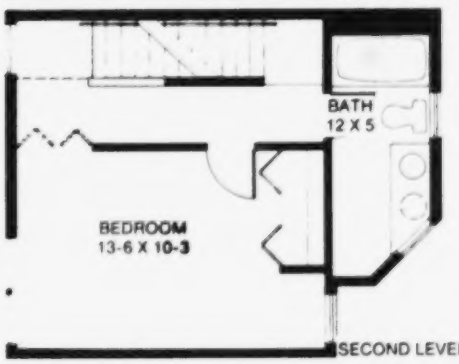


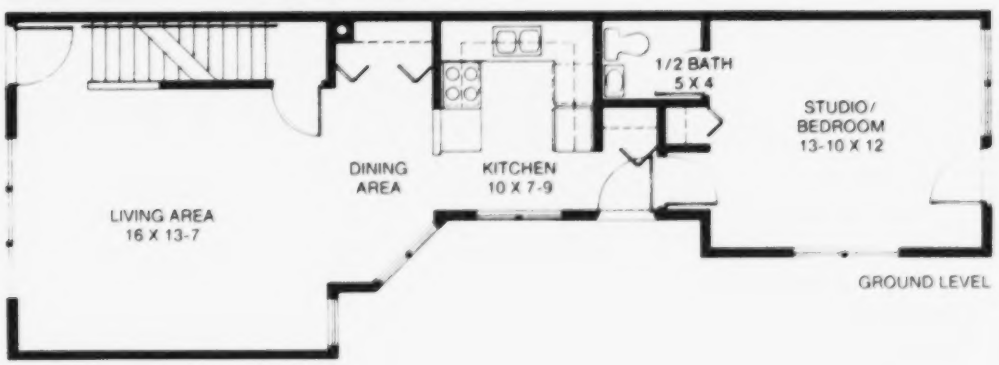
GROUND LEVEL

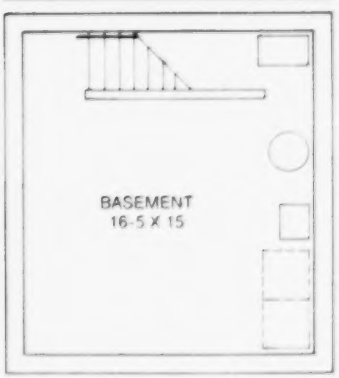
BASEMENT

DAYTON COURT









Unit A (3 Bedroom)	Gross Area Sq. Ft.
Living Area	1425
Basement	246
Garage Space	

Dimensions and square footage are approximate. Actual construction may vary.

and social service uses for different groups if subsidies are in place.[39] Flexibility is made possible by flipping units and in its potential for expansion either in the front or back yards.

Flipping units to create collective space is one way to create shared space. While this innovation is not being tried in St. Paul (two sets of interior courts still offer this possibility), the idea of shared space is occurring in plans and designs for My Sister's Place, an emergency shelter in Hartford, Connecticut.[40] A 10,000-square-foot warehouse is being renovated into transition housing, with supportive services, including child care and job development. There will be 20 apartments; three efficiencies, ten two-bedroom, one three-bedroom, and six four-bedroom units. Each unit is designed to permit sharing of bathrooms, kitchens, and living rooms.

As the New American House was transformed into Dayton Court, separate space for an at-home work space became available only in units with more than one bedroom. (Figure 5. Unit A) A question may be raised about wage labor at home: if housing is to be affordable and low-income, and given the skills low-income people have, won't work in the home be exploitative? There are no simple answers to this question. The first evaluations of modern "home-based" work are just appearing.[41] The results are mixed, but women continue to do it. Kathleen Christensen's study of 14,000 respondents included more than 7,000 who worked at home, most of them involved in clerical work (typing, bookkeeping, insurance claims rating, data entry work on computers), craftswork (sewing, knitting, embroidery), and professional occupations (accounting, architecture, planning, writing). Although the program for the New American House competition clearly had in mind changes because of the computer, Christensen found that "only one in four clerical workers and one in three professionals used them."[42] Sherry Ahrentzen's (1987) study was aimed at professional homeworkers in selected geographical areas who used a computer; all but 10 of the 104 had computers.[43] Whether or not people use computers in their home, home-based work does not automatically solve child care problems, even if a strong reason to work at home is related to child care. The finding that young children require paid or unpaid care in order for mothers to get their work done is not surprising. Rather than erasing or neutralizing benefits that can occur by working at home, it emphasizes the pressing need for child care.

Child care was not arbitrarily placed in the New American House scheme; rather it was to point out that if work were done at home, child care centers were also essential. As to the type of skills that low-income people have, inherent in the arguments made throughout this paper is the need to tie shelter to services, including job training. Because low-income people may be out of work or working at particularly low paid jobs does not mean that their future work options will be the same. Low-paid piece-work sometimes requires the same type of skills that higher paid craftspeople have, as in sewing or knitting. Job training also means enhancing people's existing skills, informing them of opportunities that may transform their individual skills in isolated houses into a thriving community-based business. This potential has been realized in women's economic development projects in various parts of the country.[44]

It is also true that subsidies are necessary to support housing and services for the homeless and other low-income people. Where innovative planning and design is occurring, providers have been able to piggyback funds through a combination of state and local government sources, McKinney funds, private donations, and income from occupants' social security supplements or general relief. Before turning to new initiatives that include funding, the next section offers planning and design guidelines.

Planning and Design Guidelines

Several planning and design principles grow out of the above discussion. These guidelines are within the framework of a family model, but they provide for a "community of individual homes" that can easily suit unrelated households. The intent of these guidelines is to serve as a reference for providers. To the extent possible, potential residents should be included in the design process, and the guidelines highlight particular places where that might occur.

First, a newly constructed or rehabilitated house should be an integral part of the neighborhood to avoid calling attention to different types of households living there. Research about subgroups of the population show they do not like to be identified because of "different" characteristics, e.g., single parents because of their marital status (Anderson-Khleif 1982), homeless because of their tenure status. This suggests that infill housing is most appropriate. The house profile should fit into the surrounding property in form and materials. Exterior walls, for example, should reflect the materials used on surrounding properties. If an existing house is being rehabilitated, there is greater likelihood that it already fits into the context of the block; designers should be wary of changing the exterior in any substantial way.

Second, private spaces are critical for inhabitants of any facility where there are also group activities. In sheltering and serving the homeless, there are rooms that will be used purposely by several people at the same time. Privacy may be found in those rooms, but this will depend on the daily schedules of residents.

Privacy may also be found outside, depending on the size of lot, proximity to neighboring houses, and landscaping. Bathroom facilities may be private. However, the single place that will accord the most privacy will be bedrooms, and where there are no individual bedrooms, territoriality will still occur around the bed itself. Designers should explore ways in which room configurations can lead to private nooks within bedrooms, as well as multiple uses of bedrooms. Developing L-shaped rooms and adapting loft spaces can create separate zones within a room. Other possibilities are designing built-in furniture to free space in the room, or creating nooks that can accommodate equipment (such as a typewriter or sewing machine) and can be used for storage or even for sleeping.

The third principle concerns encouraging a sense of community among people living in a house or apartment building. In design terms, this can be achieved by providing opportunities for social encounters (such as a kitchen large enough to accommodate the entire household eating together, even if they not do this on a regular basis). Another way to foster community is to ensure the convertibility of rooms from work areas to social areas. A garage may also double as a common utility room or play space for children.

Fourth, to the extent possible, there should be maximum flexibility in the house over time. One way to accomplish this is to site buildings in such a way that additions can be built at a later time.[45] The most important way to achieve flexibility and also encourage a sense of community is to design with the household, block, and neighborhood in mind. In Sweden, some projects have fully equipped connecting apartments that are used as day centers for children and are readily adaptable to residential uses should the future need for child care be unnecessary. Elderly housing is purposely integrated into a project for other age groups, in a separate building but connected with walkways to the collective facilities such as a dining room and kitchen, lounge, and library. It is possible for people to pass through different segments of the life cycle and move into different apartments but remain in the same community where they have formed attachments.

Fifth, to the extent possible and when appropriate, self-help or self-management should be integrated into designing, building, managing, and maintaining houses. There are a number of different ways to organize management and maintenance operations. The most familiar is through a recognized agency which, for a fee, assumes these responsibilities. But there are other options that involve varying degrees of self-management. At least one proposal suggests that opportunities should be made available for different groups to self-manage; the benefits are that residents can acquire social skills through group process and assertiveness training, making suggestions and reaching decisions about their housing and service needs.[46] There are also ways in which residents who contribute to management and maintenance can be awarded points, perhaps linked to lower costs per month.

New Legislative Initiatives

There is newly enacted state and national legislation, as well as proposed legislation, that can provide the funding to see these guidelines realized. In California, the Family Housing Demonstration Program is one piece of Senator David Roberti's Housing and Homeless Act. The act authorizes a $450 million general obligation bond issue to be placed on the November 1988 and 1990 ballots. The $15 million family housing demonstration program will offer incentives to private developers to build multiunit rental or cooperative housing, along with job training and child care services.

At the national level, Rep. Joseph P. Kennedy II has introduced the "Community Housing Partnership Act," which will provide $10 million to support expenses and training for the staff of nonprofit community-based organizations, and for the administration of education, counseling and organizing programs for tenants eligible for affordable housing. It also proposes to provide $500 million in grants to subsidize the development of affordable rental housing and homeownership.

A proposed legislative package is being fashioned by the Committee for Creative Non-Violence, the National Coalition for the Homeless, and the Union of the Homeless. It calls for $10 billion for affordable housing with child care and job training services, and at the same time strengthens existing public housing. The Jesse Gray bill, named after the late representative from New York City, is targeted to public housing, calling for the rehabilitation of 50,000 units. Rep. Ron Dellums from Berkeley, California, will be introducing a bill that is the most far-reaching, calling for funding of upwards of $30 billion for new construction and rehabilitation.

Conclusions

As steps are being taken to provide low-income permanent housing, it is important to plan for shelter that is also accompanied by services. At the same time, we need to recognize that minimum standards for emergency shelters or transition housing can create problems, particularly if the minimum standards become the maximum. Attention needs to be paid to the distribution of common spaces and collective facilities when individual units are designed. Most importantly, we need to know more about small-scale solutions, including ways to transform large-scale projects into places where there is more neighboring, and where people can find both refuge and community.

Endnotes

[1] George Rand, "Social Urban Design in Los Angeles' Skid Row," in Claude Levy-Leboyer, ed., *Vandalism, Behavior and Motivations* (Amsterdam: Elsevier, 1984), pp. 295-309.

[2] David W. Dunlap, *The New York Times*, "New York News," February 1, 1988, p. 15.

[3] Jacqueline Leavitt, *Montauk Air Force Station: From Radar to Reuse*. Report prepared for the U.S. General Services Administration, Washington, DC, 1981.

[4] Shelter Partnership, Inc., "City of Los Angeles Shelter Ordinances Interpretative Memorandum," (Los Angeles, February, 1987), p. 2.

[5] See The Urban Land Institute Project Reference File, Downtown Women's Center, Los Angeles, California, 18, 4 (Washington, DC, January-March 1988).

[6] It is my observation that the homeless become part of the landscape of refuse. Many live in the midst of discarded debris, in dumpsters and under trash receptacles. Society seems to view the people as not better than the refuse they resemble. Along these lines, George Rand (1984) writes:

> In general, it was discovered that a small number of street stains or areas of destruction (i.e., presence of garbage, graffiti, broken glass and other products of human occupancy) can have an impact on the way a community is perceived that goes far beyond their actual significance. In point of fact, the appearance of Skid Row is created simultaneously by the appearance of dirt, graffiti or garbage and the presence of 'street people.' (p. 299)

[7] The concept of leftover space is drawn from Roger Trancik (1986). Trancik refers to unplanned space between buildings and underused space such as parking lots as lost spaces, available for integrating into a more coherent urban design.

[8] Nora Richter Greer, *Search for Shelter* (Washington, DC: American Institute of Architects, 1986), p. 74.

[9] Ibid.

[10] The suggestion by planner Leland S. Burns (1986), to apply sites and services or infrastructure planning in developing nations, transforming vacant undesirable land into opportunities for more permanent housing, is intriguing. Burns is straightforward in his recommendations, arguing that "second-best" solutions, including self-help construction and upgrading existing dwellings is more cost effective and has proven to be more satisfying to squatters. There may be support for such initiatives among the homeless. In informal interviews at the Urban Campground, the author met homeless people who, without prompting, spoke of their willingness to renovate empty warehouse buildings visible from their temporary quarters.

[11] In some ways, emergency shelters are an extension of the street, but with a roof. That they are interchangeable with the street is reflected in two ways. The first is that some shelters respond to the greater demand than supply of beds by rotating people through a facility. Bachrach quotes a nun in a shelter in New York City on this:

> . . . we only have beds here for twelve women and we let twelve more women sleep sitting up in chairs. But there are thousands of women out there—thousands who have no place to live. So many ladies come here for shelter that we can only let them stay for four days before we send them back on the streets. We call it 'rotation.' Four days in, three days out. It's horrible, but we don't have much choice.

The second is that there are emergency shelters that include an outdoor area, a more protected street environment. An example of an emergency shelter that combines elements of the street within its own system is the Central Arizona Shelter Services with its dormitory for 55 women and 80 men, its annex for 250 to 300 men and its outdoor area where 400 people can sleep.

Some emergency shelters provide transitional housing as well. According to Greer, Covenant House in New York provides transitional living arrangements "to bridge the gap between emergency shelters and self-sufficiency," and Covenant House in New Orleans will be the first branch in the system to offer emergency and transitional housing. The New Orleans Covenant House will be "a complex of interconnected new buildings" for 96 youth, beginning with one small building that will be expanded. The Houston Covenant House will include a 10-bed self-sufficient transitional housing with its own living/dining area, study space, kitchen, and laundry, "similar to that found in apartments."

[12] Greer, p. 55.

[13] Ibid.

[14] Amy L. Rowland, "Providing Transitional Housing for San Diego's Homeless." Unpublished client project for Master of Arts Degree, UCLA Graduate School of Architecture and Urban Planning, 1987.

[15] There are extenuating cases where a provider develops a response to the homeless in an innovative way. Casa Nuestra in Los Angeles, for example, is transition housing that does not limit the length of stay of any resident, has allowed residents in a second house to take over the lease as permanent housing, and is renting the house next door for two senior women and their children. The Elizabeth Stone House in Jamaica Plain, Massachusetts, is providing 10 shared transitional apartments, and four long-term, two of which will be for child care providers.

Where possible, transitional housing provides more support services for a longer period of time, with some attempt to provide apartments, either for one family or on a shared basis. Material from Unity Inn, the House of Ruth in Washington, DC, reveals an explicit redefinition of community through providing transitional housing. Women under 30 years old are matched with women over 40 in order to promote a support system through counseling and to help "foster a home-like atmosphere."

[16] The issue of size has been around for quite some time, even before the awareness of homelessness heightened visibility about the lack of affordable housing. It has been at the heart of debates around minimum property standards used by federal low-income public housing programs and zoning ordinances permitting accessory apartments in residential areas. Anthony Downs has questioned minimum square footage requirements as too restrictive (Downs 1977). The question of affordability and minimum square footage also surfaced in the last decade around accessory units (alternatively referred to as granny flats, mother-in-law units, and mother-daughter units). Accessory units can either be attached to or detached from a primary residence, range from about 350 to 750 square feet, and usually have parking and occupancy restrictions so as to be compatible with a single-family residential zone.

[17] The hotel model is often talked about in the same breath with the 27 square foot Tokyo hotel room that includes a

bathroom, refrigerator, and bed for $280 a month. See *Life*, 11, 4 "Wee Wonder," (1988), p. 7.

[18]Rowland, p. 12.

[19]Illustrations of how the formula could work suggested a range of room sizes between 120 and 220 square feet. A low-income person in San Diego with the experience of having lived in an SRO suggested to the Task Force that interior design has more to do with satisfaction than size. He saw key elements as: high ceilings, platform beds, no bulky furniture, more electrical outlets, and a mixed residential/commercial use with laundry or small grocery stores on the ground floor, some parking facilities, adequate soundproofing, balconies, building wings rather than long corridors so as to encourage a feeling of privacy.

[20]Shelter Partnership, Inc. "The Short-Term Housing System of Los Angeles County: Serving the Housing Needs of the Homeless" (Los Angeles, August 1987), p. 21.

[21]Jacqueline Leavitt, "The House of Ruth," *Nation* 246 (April 2, 1988): 472-474.

[22]Thomas A. Reiner, *The Place of the Ideal Community in Urban Planning* (Philadelphia: University of Pennsylvania Press, 1963).

[23]Alvin L. Schorr, *Slums and Social Insecurity: An Appraisal of the Effectiveness of Housing Policies in Helping to Eliminate Poverty in the United States* (Washington, DC: U.S. Department of Health, Education, and Welfare, 1964); Jacqueline Leavitt and Susan Saegert, *Housing Abandonment in Harlem: The Making of Community-Households* (New York: Columbia University Press, forthcoming). One counterexample may be thought to be the ties many northern blacks have to the South, and those of Hispanic origin to Puerto Rico. A black family in New York City, for example, may send teenage children to family in the South in order to protect them from the hazards of ghetto life, namely drugs and crime. Similarly, teenage children may be sent to Puerto Rico. Alternatively, people emigrate from the South or Puerto Rico to particular blocks in particular neighborhoods of a city because friends or kin are already living there. While this can be interpreted as community without propinquity, what is at work here are dispersed kin networks rather than far-flung networks based on education and occupation.

[24]Kimberly Dovey, in "Home and Homelessness," uses the concept of commoditization to distinguish between the house as a commodity and the home as appropriated territory. She writes:

> . . . The house is a tool for the achievement of the experience of home. Yet the increasing commoditization of the house engenders a confusion between house and home because it is the image of home that is bought and sold in the marketplace. . . .
>
> Commoditization has its main eroding effect not in the quality of house form but in the quality of the relationship of the dweller with the dwelling. The house as a piece of property implies a legal relationship between the owner and the place, a relationship embodying certain legal freedoms. Home as appropriation, on the other hand, implies a relationship that is rooted in the experiences of everyday life over a long period of time. It requires adaptability, control, freedom, and security of tenure. (p. 54)

[25]Beatrice G. Roshan, "Needed: Professional Training in Housing Management." *The Journal of Housing* 3 (June 1946): 122-123.

[26]Ibid.

[27]Maxim Duplex, "The New Issue in Public Housing," *Journal of Housing* 7 (June, 1950): 202-206, p. 202; Maxim Duplex, "The New Issue in Public Housing," 7 *Journal of Housing* 7 (July 1950): 238-242; Journal of Housing "Five Design Principles of Maxim Duplex Criticized," 7 (September 1950): 299-308.

[28]Ibid.

[29]Maxim, p. 204.

[30]Ibid.

[31]Ibid.

[32]Ibid.

[33]There are situations where a long term low-income facility can add a sense of a neighborhood. Such is the hope of the Cecil Hotel, writes Greer, an SRO in New York City, "in a transitional neighborhood," with other nearby residential and commercial projects under way.

[34]Leona L. Bachrach, "Homeless Women: A Context for Health Planning," *The Milbank Quarterly* 65 (1987): 388.

[35]Cecilia Henning, "The Social Services as "Network Organizers." A research report for the Swedish Building Council, English translation, 1987.

[36]For a fuller discussion about the New American House, see Jacqueline Leavitt, "Two Prototypical Designs for Single Parents: The Congregate House and the New American House," in Sherry Ahrentzen and Karen Franck, eds., *Alternatives to the Single Family House* (New York: Van Nostrand Reinhold, forthcoming).

[37]While zoning and NIMBY's were not a problem in St. Paul and variances for reducing parking were approved, delays in moving a project along can add to costs. With the New American House, for example, the longer it took to find a site, the more costly the development. With rising costs, it became increasingly unlikely that lower-income non-traditional households would be able to afford the units. As the New American House was redesigned to conform to a larger lot, the single most important cost innovation has been the creation of the two small units.

[38]Although I have referred to the combined work space as a child care center in other writings and speeches, attention is called here to the physical requirements usually required by municipalities to provide adequate open space, as well as minimum square footage, for child care. Even in the original design, then, the conversion of only two work spaces would not have permitted a formal child care center.

[39]The potential creation of accessory units as rental property has been built into other projects. The most important element is providing connections for utilities at the time of construction. In some cities, building inspectors are reported to be "looking the other way" when certifying the property as a single family residence.

The Los Angeles Community Design Center developed prototypical kits for care facilities, 24-hours and less than 24-hour care, in a licensee's own home or in other locations. The program type included the following: foster family home, small family, large family home for children, large family home for adults, group home for children, group home for adults, social rehabilitation center, a small family day home for children, a large family day home, a day nursery, a day care center, a social rehabilitation center.

[40]Interview with Judy Beaumont, director of My Sister's Place, April 26, 1988.

[41]Kathleen Christensen, *Women and Home-Based Work: The Unspoken Contract* (New York: Henry Holt and Company, 1988). Christensen's work was based on a national survey of 14,000 women and in-depth interviews with over 100. Also see Sherry Ahrentzen, "Blurring Boundaries: Socio-Spatial Consequences of Working at Home," a report sponsored by the National Endowment for the Arts and the University of Wisconsin-Milwaukee, June 1987. Ahrentzen's work was based on a survey, interviews, and a physical inventory of the home and workspace of 104 professional homeworkers in various occupations.

[42]Christensen, p. 5.

[43]Sherry Ahrentzen, Blurring Boundaries: Socio-Spatial Consequences of Working at Home. A report sponsored by the National Endowment for the Arts and the University of Wisconsin—Milwaukee, June 1987.

[44]Research drawn from Margaret Murphy on women's economic development, 1987, in the author's files.

[45]Alternatively, the designer can consider the possibility of providing footings that can withstand adding stories to the structure of the house. This may prove to be costly and should be measured against other design and marketing decisions. A flat roof will also lend itself to adding stories later on.

[46]In correspondence with the author, Enid Gamer, Coordinator, Child and Adolescent Services, South Norfolk, Massachusetts, Area Office, Department of Mental Health, suggested that using self-help in the planning and construction stages of single parent housing is a positive way of overcoming isolation.

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Exploring Intergovernmental Responses | *Part II*

Hope for the Homeless—Local and State Response

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With increasing intensity over the past eight years, the nation's attention has been drawn to the situation of the homeless. The politics of states and localities have been roiled, the media have been mobilized, and the U.S. Congress has been influenced to provide over $1 billion under the rubric of homelessness through the *Stewart B. McKinney Homeless Assistance Act of 1987 (McKinney Act)*. Cities and states have found themselves devoting greater attention and resources to alleviating the plight of the homeless in their jurisdictions. Studies have been undertaken by many jurisdictions and by the national government. Yet, with all this activity on behalf of the homeless, there is no accepted or established strategy for dealing with homelessness, and no consensus on its causes or cures.

This is a curious turn of events, if only because governments usually have some idea of what they expect to accomplish when they undertake major efforts, even emergency efforts, even if that idea is later proven to be wrong. Whether it is a war on poverty based on a misconception of the causes of juvenile delinquency, as described in Daniel Patrick Moynihan's *Maximum Feasible Misunderstanding*, or the inauguration of mortgage insurance to repay veterans and to provide a foundation for a housing industry, policy is usually based on some understanding of the problem being attacked and the appropriate means to cure it. Sometimes the federal, state, or local government is right, occasionally it is wrong, but it is rarely stampeded into action just because it is confused.

In the case of homelessness, many state and local governments are in the same plight as the federal government, operating in a fog, but spending money and energy nevertheless. There are, however, exceptions. A number of governments, especially state and

local governments, have taken the time to get some kind of handle on their homeless problem—identifying its size and nature, assessing their resources, and trying to determine the best policies for sheltering their homeless, and, to the extent possible, obtaining the social, psychological, or housing services to move the homeless into stable living environments. Effective and soundly based homeless policies have been developed in places as widely disparate as St. Louis, Boston, Denver, Los Angeles, and the State of Ohio.

As a result of the growing state and local efforts to plan and implement coherent policies for helping the homeless, it has become possible to think the unthinkable. The problem of homelessness may well be manageable. In fact, it appears to be on the verge of being managed by state and local governments, with relatively little federal support and with little federal interference. This last situation may be about to change, due to the sizable federal financial and regulatory wave that is about to descend on the localities.

It would be advisable, therefore, to get a better picture of exactly where we are in ministering to the homeless, what we know about the nature of the homeless problem, what local strategies appear to be working, what, if any, additional federal help may be useful or counterproductive, and what, overall, is the appropriate relation of the federal, state, and local governments in managing policies to address the needs of the homeless.

The Homeless Problem and Response to Date

We cannot continue to address the situation of the homeless as if it has not been studied responsibly at both national and local levels, as if the American people have not devoted a good part of the substance of their lives and incomes to taking care of the poor, including the homeless, and as if state and local governments and private agencies have not been working, in dedicated fashion, for at least the past eight years—though actually much longer—to alleviate the problems of the homeless. Out of these years of study and effort, it is possible to piece together a picture of a significant national effort, though a predominantly local and private effort, which is within sight of noteworthy successes in treating homelessness, and may well be prepared to move to a second phase. The first phase has been identified as sheltering the unsheltered. The second phase would be providing services to stabilize the lives of the homeless.

Homelessness appears to be a problem uniquely suited to being addressed by local groups and governments. In almost every locality, homelessness is of a size that can be identified and managed by using locally available resources, although some of those resources may involve the use of existing federal financing. While some major cities have nightly homeless populations that appear to range from .1 to .5 percent of their total populations, most other areas have an incidence of homelessness at .1 percent or lower, according to local area studies.[1] Thus, homeless numbers in most localities will be in hundreds, or in small localities, dozens, a level that local churches, private agencies, and public bodies can focus on and serve. The characteristics of the homeless population vary enough from locality to locality and the problems of the homeless are so individualized that they require the type of intimate problem solving best handled by local agencies.

While there has been no complete, nationwide, fully comprehensive study of homelessness using intensive street surveys, there have been a large number of studies of homelessness in individual cities and a few efforts to gauge the nature of homelessness as a national issue. The most significant attempt to assess homelessness on a national basis remains the 1984 HUD study *A Report to the Secretary on the Homeless and Emergency Shelters*, based on four different methodologies, only one of them using a street census.[2] This study did set parameters on the characteristics of the homeless population that have tended to be confirmed, within reasonable ranges, by a multitude of more intensive local studies. The study provided the first well-founded national estimates of homelessness, assessing the single-night homeless population at between 250,000 and 350,000. Interestingly, the individual city studies that have been done since the HUD study, besides giving general confirmation of the HUD profile of homeless persons, have tended to produce lower numbers and proportions of homelessness on a per city basis, as is indicated in Table 1. This is probably due to the fact that most of the HUD methodologies involved the use of expert estimates, and most people making estimates of this sort appear to use high estimates for fear of understating the problem. The local studies are geared more to harder counts of homeless persons, including street surveys to identify the homeless population outside shelters.[3] The often asserted figure of 2-3 million homeless originated in a series of unsubstantiated responses by homeless advocates to congressional committees and the media. There has never been a scientifically, or just reasonably based, survey or count of homelessness in as much as a single city which could justify such a national estimate, even as a yearly total of homeless, never mind a single night estimate.

In addition to local studies directed toward action, there are also seat-of-the-pants estimates, such as those provided by the U.S. Conference of Mayors.[4] Though unreliable for anything more than

Table 1

Illustrative Profiles of Homelessness

	Magnitudes		Selected Causes		Social Unit	
	HUD 1984 Estimate[1]	Local Study[2]	Mentally Ill (percent)	Substance Abuse (percent)	Families (percent)	Singles (percent)
National	250,000-350,000	—	22	38	21	79
Chicago	19,400-20,300	2,722	25-33	33	19	81
Boston	3,100-3,000	2,863	27-35	25-59	18-20	NA
Denver	—	1,500-2,900	40	33	NA	NA
Los Angeles	31,300-33,800	4,500-7,000	68	46	10	90
Fairfax County, VA	—	654	29	44	30	70

NA—Not available

[1]U.S. Department of Housing and Urban Development (Washington, DC: HUD, 1984).

[2]Peter H. Rossi, Gene A. Fisher, and Georgianna Willis, *The Condition of the Homeless of Chicago* (Amherst, Massachusetts, and Chicago: Social and Demographic Research Institute and NORC, A Social Science Research Center: September, 1986); Hamilton, Rabinovitz and Altschuler, Inc., *A Social Services and Shelter Resource Inventory of the Los Angeles Skid Row Area* (Community Redevelopment Agency of the City of Los Angeles, California: 1986); *Making Room: Comprehensive Policy for the Homeless* (Boston: City of Boston, November 1986), pp. 42-7; *Report of the Homeless Action Group* (Denver, Colorado: February 1987); Suzanne Weiss, "Study Cuts Size of Denver Homeless," *Rocky Mountain News* (February 5, 1987); Eric Goplerud, "Homelessness in Fairfax County: Needs Assessment of Homeless Persons Submitted to Fairfax County" (August 21, 1987).

impressions, these estimates do confirm the general patterns.

Many policymakers and commentators have taken to dismissing questions about the size of the homeless population and, to some extent, its characteristics in order to avoid what appear at times to be fruitless fights over the methodology of counting and the existence of hidden agendas. Initially, there may have been some virtue in this attitude from the perspective of action, because the gap between the available basic shelter and any possible number of homeless persons was still large regardless of their numbers or characteristics. As the capacity to shelter the homeless has burgeoned, however, the questions of size and character attain a very specific policy relevance. The direction chosen over the next year or so by the federal, state, and local governments is likely to determine the success or failure of this large, compassionate effort, and the choice between two major policy directions will quite likely determine that success of failure.

To put the issue most bluntly, if we were to believe that there was a homeless population as large as some homeless advocates assert, 2 or 3 million, or 1 percent of the nation's population, then there would appear to be only one viable emergency strategy—some variation of warehousing. On that basis, we would currently be about 1.8 to 2.8 million beds short. Even if we treat the hypothetical 2-3 million figure as a yearly total, implying a single-night population of perhaps 1 million, we would be about 800,000 beds short. At that point, we would have to say, given everything else that is going on in this nation, from AIDS research to the budding crisis in education, and the exhaustion of resources that is looming, that it does not make any difference how we assign roles to deal with the crisis. All the governments, and all the private agencies, and all the king's men, would be unable to deal with the situation.

Fortunately, as Ben Wattenberg has pointed out in a different context, "The good news is that the bad news is wrong." The likely size of the homeless population is approximately the same as it was in 1984, but the capacity to shelter that population is approximately doubled, and attention to the needs of the homeless has moved up a whole notch on the Richter scale of public issues. This opens up the consideration of a different direction for the next phase of service to the homeless, already reached in many localities. Once adequate "rush-hour" shelter has been provided, the real task begins, that of enabling the homeless to receive the economic, social, and psychological services that are available, but which frequently elude them when they are uncounted, unlocated, and frequently invisible to the bureaucracies that exist to serve the poor.

These two policy options, warehousing and servicing, tend to be mutually exclusive, depending on the numbers assumed or identified. Large expenditures of time and energy for warehousing will preempt service provision. Given what we know of the homeless population from existing efforts, however, warehousing will be a tragic waste. This is, however, the type of solution that the federal government is likely to foster. The *McKinney Act* programs already show a typical congressional bias toward size rather than accuracy in creating pro-

grams, and reflect the eternal federal need for regulatory and record-keeping burdens.

Overall, the serious studies undertaken by states and localities, along with the HUD study, have tended to paint a consistent picture of the homeless, but a picture with noticeable local variations. Cities differ markedly in their identified percentages of the mentally ill and substance abusers, as well as their percentages of homeless families. This has meant that worthwhile local policies are dependent on accurate analysis of the local situation, with greater or lesser emphasis on different policy alternatives. For example, a city that identified a high proportion of family homeless, such as New York or Norfolk, will have different service problems than Chicago or Los Angeles, which have homeless populations dominated by single adults. Yet, in each case, it is known that a large proportion of the overall homeless population is either mentally ill or subject to substance abuse. The ramifications of local analysis are felt most in specific decisions about numbers and types of shelter to be provided, relative need for detoxification or psychological services, and similar choices.

State and Local Capacities and Successes

Over the past seven years, there has been a quantum leap in the will and capacity of local communities to shelter the homeless. By 1984, the HUD study observed a 41 percent increase in shelters from 1980.[5] Since 1980, Los Angeles has provided more than 1,200 beds to supplement 1,000 beds in its Skid Row area.[6] By 1987, Boston had increased its shelter beds to 2,113 from 972 in 1983, more than doubling capacity.[7] Denver, having identified the size and character of its problem, developed a capacity of about 1,000 beds, and it supplements those with vouchers for situations of extraordinary demand.[8] St. Louis built a network of private shelter providers supplemented by government support to meet its demand for homeless shelter and services.[9] States and localities have been able to make use of funds from the Federal Emergency Management Agency, and from community development block grants. As a result of such efforts, we are beginning to get clear signs that a corner has been turned in providing basic shelter. There have been nights during the past bitter winter when cities, such as Denver and even New York and Washington DC, have been able to point to significant numbers of available beds left over after sheltering the homeless, although Washington, DC, had to open public buildings to accomplish this.[10] Boston would seem to be within a few hundred beds of its homeless count. Over the past few years, major increases in demand for shelter have been reported by cities. Although frequently taken by the media to be symptomatic of increases in homelessness, this is more accurately portrayed as a result of shelter services catching up to the existing homelessness. It is likely that, if we have not already done so, we are reaching a level of shelter service that can meet the demand. In New York, for example, the shelter population may well have peaked, at about 28,000. There is significant recent evidence that the proportions of unsheltered individuals, which were never as great as was, for safety's sake, projected, are declining.[11] Boston was able to report in its most recent study that the numbers of unsheltered children had dropped from 42 to zero.[12]

Beyond just providing shelter, however, the most positive aspect of the response to homelessness has been the ability of many local and state governments to develop and implement plans in a rational fashion, using public and private resources. In Denver, the city's planning enabled it to distinguish its ongoing need from a "rush-hour" emergency need, to arrive at a plan in which 1,000 beds is the fixed capacity, backed up by a fluid emergency voucher system enabling it to serve as many as 1,500 homeless if necessary. St. Louis' network of services among the private agencies, supported by funds provided by the city, has met its shelter need, but, more importantly has plugged the homeless into a network of psychological, employment, transportation, and other services. Given the actual counts of homeless people in most jurisdictions, localities in general are finding the problem addressable with local resources. Suburban jurisdictions appear to be finding the homeless population to be about .1 percent of the total population, or roughly the national average. In a county such as Fairfax County, Virginia, this implies a homeless population of 600-700, a number reasonably within the resources of the county to meet.[13]

There is a caveat in this. City governments that attempt to treat the problem of homelessness without mobilizing the local networks of service agencies, especially private agencies, can find themselves in over their heads. The 1984 HUD study showed that as much as 90 percent of homeless shelter was provided by private agencies. The increased public attention to the problem and the rapid doubling of available shelter may be leading local governments to think that they should take primary responsibility, not only for coordinating local homeless policy, but for actually financing and supplying shelter and services. Much of New York City's difficulty in handling its homeless problems may stem from too great a reliance on unsupported governmental subsidy programs, which isolate the homeless and those in emergency housing from the broad web of potential services and may inhibit escape.

Although we can point to growing success, at least at the level of providing basic shelter, we are still in an exploratory phase of homeless policy. To begin with, major policy questions still have not been answered on the most appropriate way to treat homelessness. At the same time that cities, states, and their private sectors are rushing to provide shelter, their successes are forcing us to confront head on a series of civil rights issues involving the homeless. In New York City, the question comes down most starkly to the fight over whether an individual can be forced into shelter if local authorities believe the person to be a danger or health hazard to self, others, or the community in general. If, as appears almost certain, up to one-third of the homeless suffer from debilitating mental illness, and another large portion are suffering from substance abuse problems so severe as to make personal responsibility impossible, then to leave such homeless persons on their own is virtually to condemn them to a relatively rapid death. At the same time, in an expansive concern for human rights, we have apparently decided through our court system that we cannot take them off the streets, even though we force excessively rational middle-class yuppies to fasten their seat belts at the risk of fine, forbid people to smoke almost anywhere, imprison people for driving while intoxicated, and are considering whether to require citizens to take urine tests for drugs and blood tests for AIDS.

At the very least, we have created a series of extraordinary political paradoxes. We feel obliged to provide shelter for people, and not to force them to take it. Were that not enough, the debate in Los Angeles has raised questions about whether the homeless should be searched by shelter providers in order to protect the homeless. As many homeless advocates are aware, some of the homeless appear to insist on staying on the street because they believe the street to be safer than the shelters. However, when Los Angeles set up shelters under the aegis of a private charity, some homeless advocates raised very vocal concerns over the charity's policy of searching shelter users. On the other hand, every shelter provider, ethically and perhaps legally, is responsible for the safety of the homeless they serve, and may be sued if someone is harmed while in their care. More importantly, no provider wants the homeless to be harmed in a shelter, or to be afraid to enter a shelter for fear of being harmed. Yet, with a high proportion of drug users and a significant number of felons in the homeless population, proper care and some form of protection is necessary.

Another issue revolves around the very definition of homelessness. In some instances, especially in cities which have extensive provision for emergency shelter for families, the families have been housed on an "emergency" basis for years in a single small hotel room, for which the city or state may pay more than a year's normal rent every two months. Now, the IRS thinks you are permanently housed if you are anywhere more than 39 weeks, and motor vehicle bureaus may think it takes only a month. Under the false title of homelessness, we have relegated many thousands of people to permanent residence in utterly inadequate housing. We seem to call such people still homeless to avoid facing what we have actually done to them. Aggravating the harm, such long-term "emergency" measures make schooling and employment almost impossible.

Then there is the question of the causes of homelessness. The profile of the homeless population is not quite the same as the discussion of the causes. For many, homelessness may be just the effect of public policy run amok. Of course, there is probably nothing concerning homelessness about which there is more disagreement than the question of which amok public policy is more responsible, and under what circumstances. It could be deinstitutionalization of the mentally ill, or its progeny, noninstitutionalization. It could be rent control, and its cousin, destruction of SROs and low-income housing. It could be the general destruction of two-parent families or the epidemic of drug addiction in low-income communities. The question of the cause, or causes, is not irrelevant to policy because if the cause is still operating, nationally or in a given locality, homelessness will continue to be generated. In addition, in order to act in individual cases, it is important to understand whether homelessness is inflicted by individuals on themselves or by larger institutions upon them. Every person reading this knows the answer to all of these questions, of course. Two of us may even agree. Once we get past the question of basic shelter, however, providing significant help to the homeless depends on guessing at least some of these things correctly.

There are many other issues, not quite as thorny, but just as real, struggled with by those providing shelter to the homeless. It is important to recognize that we do not yet know what is the single best way to handle these issues, or even whether there is a limited number of acceptable alternatives. Different localities are attempting vastly different solutions. In some cities, the homeless are being required to take shelter. In others, they are left free, but the local government is chastised every time a homeless person dies on the street. In some places, the homeless are frisked and watched carefully in shelters. In others, the providers absorb the risk of assaults and robberies. Some localities are limiting the time people can spend in shelters. Some private shelter providers had already imposed their own limits. Communities differ in the reliance they put on

private charities and churches, and some governments have decided this is entirely a private responsibility. What community experimentation with homeless policy most closely resembles is the ferment in the scientific community over AIDS research or superconductors. No one knows which formula will work best, or whether many will. In some respects, almost all of the formulas are working to some degree.

This is precisely the type of situation in which the American federal system works at its messy best, simultaneously exploring a multitude of alternatives in the hope of finding the most workable ones, the governmental equivalent of an analog computer. What is most important now is to let the process complete itself, to let the proposed, real life solutions be tested and assessed by people with the most clearly vested interest in success, the local communities.

The Dangers Ahead

Once the multicolored nature of the current problem of homelessness is faced, with its crazy-quilt pattern of dilemmas and paradoxes, the one thing that is clear is that we cannot afford either to stifle the creative policy activity that is currently operating, or to prematurely impose one, gargantuan, uniform solution, hoping blindly that this is the right one.

The current patchwork of local homeless policies has grown up, and is growing, without much in the way of federal help or interference. About $300 million in Federal Emergency Management Agency (FEMA) funds has been spent, and states and cities have apparently used upwards of $150 million in available Community Development Block Grant (CDBG) funds. As of this writing, significant money from the *McKinney Act* funds has not been long on the streets, so we are looking primarily at local policies arrived at with mostly local initiative, although in some instances with strong help from the courts.

This embryonic situation has let local bodies be as idiosyncratic as desired in the formulation of their policies, subject to the ever-present oversight of the judicial system. As in the early stages of a testing program for disease treatment, we should not jump too soon on an apparent cure, or give up too quickly on something that appears to have near fatal side effects. For example, my own tendency would be to consider much of what is going on in New York City as potentially fatal, from the city's overall housing policy to the reliance on state and city subsidies and virtually unaided governmental exertions.[14] St. Louis' example, on the other hand, looks almost like a form of AZT for homelessness, requiring that we stop all other experiments and insist on its use. In fact, it is too early to say, at least in regard to St. Louis.

There are many other cities with active and effective plans, some of them involving less private activity. Cities with different homeless profiles may need different balances of services. To impose any single solution, no matter how promising or abstractly satisfying, would be disastrous.

Premature hardening of policies is one of the dangers of too great a federal role in homeless policy. The federal government, being a single government, tends not to brook great diversity, much as, sometimes, it says it does. States and local governments know this, so when the federal government sets policy, even if that policy formally allows broad latitude, the states and localities always ask, "What do you really mean?" And the federal government always tells them, usually through regulations. Thus, one goes from a broad community development block grant program to a lightly disguised, tightly controlled housing rehabilitation program in the 1970s, and then sees the return of rigidities in the past few years after the streamlining of the early 1980s.

A federal homeless program, even an incoherent hodgepodge like that embodied in the *McKinney Act*, with funds scattered across 12 programs in four agencies (interpreting conservatively), will eventually have regulations that will bind, intimidate, and narrow practices. HUD has four programs in at least three different program offices. Some of the money is given out by formula, some by application. Not knowing what might be the cause or cure for homelessness, the Congress spread the money over a list of likely suspects. There is no guarantee that the money will go to localities with the greatest need or, given the categorical nature of many of the programs, that the program needed will get money to the place with the specific need. To make matters worse, in some of the programs, as the General Accounting Office pointed out, there is no guarantee that the money will go to the homeless at all.[15] Given the complexity of the *McKinney Act*, it is likely that we will add the typical federal problems of interagency rule conflicts and lack of coordination. Everyone's regulations and enforcement patterns will be different. If the federal presence becomes dominant, it is likely we will end up with either a scattered homeless effort with no real force, or a narrowly framed homeless policy which works, if at all, in only a few places. Since we do not know what works best where, the odds on picking the most widely appropriate homeless policy are extremely slim.

There are two other dangers, beyond that of settling too fast on a uniform policy. Federal programs are not very hospitable to private cooperation. The federal government has a tendency to think that any policy it must get involved with is one that must be handled by naked, unaided government.

Sometimes it is based on constitutional interpretations, such as the recent HUD decisions limiting aid to religiously affiliated shelter providers. More often it is just an opinion, rife in Washington, that if there is a federal action involved, the private sector has forfeited its claim to a functional role. At the very least, any private sector agencies involved are likely to find themselves suddenly faced with an avalanche of inhibiting reporting requirements and an atmosphere of general suspicion. Private sector involvement withers. In the case of homeless policy, private sector involvement, which is strong and effective in most cities, is absolutely crucial. We cannot afford to lose it.

The last is simply a function of the money. Federal money overwhelms, even when it is not overwhelming. Local governments replace their own investment with federal funds. The private sector sees it flowing, and pulls back. All of a sudden, what has been a thriving local effort turns into a bureaucracy, perhaps with nominal local government and private participation, but still something provided by "foreign" investors. One of the interesting things about local public-private initiatives, from industrial parks to special olympics, to new hospitals or weekend park cleanups, is that they want to win. Set up a local public-private initiative on homelessness, and there is a strong chance that people will not stop until there are no homeless on local streets, and there is a least an established network of services to move the homeless into more of the mainstream. Turn it into a federally funded effort, and it will become a bureaucracy, with its main goal being satisfaction of appropriate procedures for disbursing and accounting for appropriated funds. The elimination of local homelessness will be strictly coincidental—and highly unlikely.

The Next Phase

Homeless policy is leaving the phase when its almost exclusive concern had to be the provision of basic shelter, when there was much confusion about the size and characteristics of the homeless population, and when clarity about subtleties of policy were unimportant because anything which created beds looked like good policy. In this confusion and frenetic action, much good has been accomplished, and some of the cooler heads and cities appear to have not only solved their basic problem but also begun the move to more sophisticated service. There appear to be very few communities in which we have not either reached, or gotten in sight of the goal of sufficient facilities to handle both average and peak demands for shelter.

The next phase has two privacy characteristics. It will be the period when the widely varied local policies will be tested for adequacy, in the courts and in public judgment. It is quite possible that a wide spectrum of alternatives, suitable to disparate community standards, will become current, and will all meet the test of court acceptance. Some policies will simply be rejected. The second characteristic of this phase will be the provision of services to the homeless. Most of the services to be provided are already available, but simply are not used by people who have no fixed homes and lower than normal coping skills. As we are more successful in stabilizing the locations of the homeless, even if the locations are only shelters, it will be possible to provide for them the full range of services for which taxpayers have already paid.

Recommendations

To a great extent, the recommendations that follow are based on successes that are already being achieved by many localities. They represent some elements of what may eventually prove to be a consensus on homeless policy, achieved from the ground up.

State and Local Governments

1. *Count the Homeless.* This may seem basic, but it is clearly part of any successful strategy. Local universities will probably be only too glad to help. The primary advantage of a local count is usually the clear indication that the problem is manageable. Since most of the larger cities, with the larger proportions of homelessness, have done counts, the remaining cities that have not done so will probably find homeless populations in the hundreds, most likely in the range between .1 and .2 percent of the city or county population, or less. As one provider in Los Angeles noted after its study indicated a homeless population only a fraction of the size of the HUD estimate, unreasonably high figures can dispirit and intimidate potential service providers. Only when realistic and honest numbers are used will "people want to help because they feel they can really make a difference."[18]

2. *Maintain a Flexible Sheltering Policy.* Do not fall in love with hardware, or capital investment in shelters. Planning for homelessness is like planning for rush-hour traffic; you cannot justifiably build for peak usage because average usage will be much lower than that on the worst days of winter. In addition, excessive shelter building will divert resources from services. It is better to have contingency commitments for short-term crunches, from churches, public buildings, and through emergency voucher programs, than to attempt to keep up unused shelter beds.

3. *Keep a Strong Role for the Private Sector.* Preferably a dominant one. Government actions alone are likely to be insufficient. For one thing, government standards of success differ markedly

from private ones. In addition, strong participation by the private sector agencies will tend to keep the community's action and investment visible, which will tend to maintain necessary pressure on public officials. Nothing is more likely to remove an issue from the front pages than the establishment of a bureaucracy to handle it. Private sector psychological investment will deteriorate, and with it commitment of funds and energy. Until the locality has visibly achieved its goals in homelessness, government roles should be kept as low as possible.

This point cannot be stressed too strongly. States and localities with strong subsidy presences through emergency grants appear to have created the impression that homelessness is entirely a governmental problem. In such instances, it can prove impossible to set up extensive networks of support services. Where governments have, for example, provided support only to charities, shelter and service providers appear to have had much more success in moving the homeless into regular welfare and housing programs than localities which have attempted to go it alone.

4. *Establish Networks.* Shelter will not be enough. The homeless will require psychological, social, employment, educational, transportation, day care, and other services. Most of these are available, either through existing federal, state, and local programs or from the private sector. Once the homeless are in shelters, they are reachable. It is important that they be reached, immediately and often.

Homeless individuals and families, with their high incidences of mental illness and drug and alcohol abuse, suffer from an inability to gain access to services for which they would otherwise be eligible. If left on their own, they will not make use of the available resources, and may well return to the streets. A local community which desires permanent amelioration of the condition of homelessness must recognize that once networks are established, entry for the homeless may well have to be forced and a certain amount of pressure maintained on the homeless persons to keep them participating. The advantage of service networks where they have been established is that most if not all of the individual social service cracks through which the homeless tend to fall can be covered.

5. *Reassess and Reform Local Housing Policies.* A variety of local housing policies, from destruction of residence hotels and single room occupancy dwellings, to overly elaborate building code requirements, zoning restrictions, and rent and development controls, have wreaked havoc with the supply of low-cost, easy to enter housing in a number of major urban areas which have high incidences of homelessness. Localities will need to reestablish flexibility in zoning and tolerance of inexpensive housing alternatives, plus eliminate laws and regulations which raise high entry barriers to the poor and restrict access to housing.

Federal Government

1. *Recognize that the Primary Roles in Homeless Policy Belong to State and Local Governments and the Private Sector.* Different localities will arrive at different solutions, in keeping with local standards. The national problem of homelessness can be managed at the state and local levels, using local resources and existing federal programs. There does not need to be one uniform national homeless strategy.

2. *Minimize Regulatory Restrictions under Existing Law, and Avoid Undue Regulations on Newly Passed Programs.* There is a real danger to local initiative in the *McKinney Act* funds, even without excessive regulation. Local action will be severely inhibited if the already committed federal funding turns out to involve (as it always does), extensive and intrusive monitoring, heavy auditing and review, and large paper work burdens. At the very least, such federal activities will require the creation of large local bureaucracies and the gradual squeezing out of private agencies.

Beyond the *McKinney Act*, there are still many federal restrictions which inhibit treatment of homelessness. Some progress has been made, for example, allowing the use of Section 8 housing certificates for single-room occupancy, but there are still significant prejudices which prevent use of federal insurance programs for alternative forms of housing, such as residence hotels. We can press harder to accept inexpensive but safe forms of housing for the poor and homeless.

3. *Avoid Further Federal Increases of Spending on Homelessness, at Least until Adequate Study Has Been Made of the Success of Local Endeavors and Existing Programs.* At this point, the federal government is shooting blind, whereas state and local governments are in the process of implementing coherent homeless policies.

4. *Search for Innovative Intergovernmental Methods to Overcome Problems of Existing Homeless Services.* One example might be to allow local emergency family programs to "purchase" vouchers, allowing families in expensive shelter hotels to move to apartments in communities near jobs and educational opportunities, stabilizing the families in identifiable communities, if not within the original city, then in nearby communities or other locations within the state.

Housing families in welfare hotels, or "temporarily" in motels, can cost as much as $15,000 to $25,000 per year, occasionally more. A housing

voucher costs approximately $4,000 per year. It would be worth looking at the possibility of allowing fungibility across state, local, and federal programs to allow for the less expensive alternative to be used.

5. Encourage and Allow Diversity in Homeless Policies. The federal government must avoid the temptation to mandate a limited number of ways of approaching the homeless issue. Localities will arrive at approaches that appear strange or even unacceptable in other areas of the country, but as long as those approaches prove acceptable to the courts, they should be tolerated. Eventually, a consensus about successful approaches will develop, but it is likely that there will be at least as much variation as there is in current state welfare or unemployment policies.

6. Perform the Dreaded Clearinghouse Function. Admittedly, the clearinghouse function is a perennial recommendation to the federal government. However, there are probably few issues to which this function has been more appropriate, given the difficulty of obtaining useful data on a wide scale and the need to address the issue at very local levels. The Interagency Council established under the *McKinney Act* provides a useful center for such activity.

Endnotes

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[11] Richard B. Freeman, "The Magnitude and Duration of Homelessness," paper presented to the American Association for the Advancement of Science, February, 1988.

[12] City of Boston, *Making Room: Comprehensive Policy for the Homeless*, p. 45.

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Homelessness: Federal and State Legislative Solutions

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Today in America more people are homeless than at any time since the Great Depression. All signs are that the numbers of homeless persons will continue to increase. Furthermore, as the supply of affordable housing continues to shrink, many more people will struggle at the brink of homelessness.

Recent studies of the homeless population across the country paint a grim picture. Virtually without exception, the reports from those on the front lines—including service providers and local government officials—is that record numbers of persons are now becoming homeless, and the demand for even the barest emergency shelter greatly exceeds the supply.

Yet, while homelessness continues to explode, solutions have been slow in coming. Among local communities, for the most part, the response has simply been inadequate. In some cases, local governments have reacted with hostility, seeking to sweep the homeless away.[1] In a few cases, local governments have taken positive steps to address the problem.

At the federal level, recent policies have not only failed to address homelessness but have also caused and exacerbated the problem. Only in 1987—following extraordinary public pressure—did the federal government enact comprehensive aid for homeless persons. Yet this new law—the *Stewart B. McKinney Homeless Assistance Act of 1987 (McKinney Act)*—provides only emergency relief. It is an important first step, but much more remains to be done.

At the same time that the gap between the need and the available resources has deepened, public concern over the plight of the homeless has escalated. Recent polls indicate that providing solutions to homelessness is now a top priority for the

American people. Solutions to homelessness do exist; they can and must be implemented.

This chapter presents an overview of contemporary homelessness and discusses some of its major causes. It then outlines legislative solutions—both federal and state—and discusses some strategies for their implementation.

Magnitude and Nature of the Crisis

The past decade has seen an explosion in the size and scope of the nation's homeless population, creating a demand for emergency shelter that has far outstripped available resources. And as the causes of homelessness remain unaddressed, its effects continue to spread across demographic and geographic boundaries.

Statistically precise figures on the total number of homeless persons nationwide are neither available nor particularly useful. Current estimates, ranging up to 3 million, leave no doubt that, by any standard, homelessness has reached crisis proportions.[2] There is no dispute that the numbers of homeless persons are growing at dramatic rates. Surveys undertaken in cities around the country found an average increase of 20-25 percent nationwide in 1987 alone.[3] As the National Governors' Association Task Force on the Homeless recently reported, "in the course of the last few years, homelessness in the United States has quietly taken on crisis proportions."[4]

Moreover, not only is the number of homeless persons increasing, but the scope is also broadening. The old stereotype of the single, white, male alcoholic—the so-called "Skid Row derelict"—no longer applies. Increasingly, the ranks of the homeless poor are comprised of families, children, ethnic and racial minorities, the elderly, and the disabled. Homelessness can no longer be considered a social aberration; rather, the face of America's homeless now mirrors the face of America's poor. Perhaps the starkest indication of this diversity is the fact that, today, the fastest growing segment of the homeless population consists of families with children.[5] In some areas, families with children comprise the majority of the homeless.[6]

Recent studies reveal the following rough portrait of America's homeless poor:

- Families with children now account for 33 to 40 percent of the homeless population.[7]
- Over 30 percent of homeless persons are veterans.[8]
- About 30 percent of homeless persons suffer from mental disability.[9]
- 20 to 30 percent of the homeless poor are employed.[10]

Homelessness is not restricted to large urban areas. Smaller cities—many for the first time in their histories—are being forced to open or finance emergency shelters.[11] Similarly, homelessness is affecting suburban communities; a recent study revealed thousands of homeless persons in Nassau County, one of New York City's most affluent suburbs.[12] Furthermore, while economic hardship and farm foreclosures continue to rise in the nation's farmbelt, the rural homeless, though less visible, steadily increase.[13]

The immediate causes precipitating homelessness in any individual case, of course, vary. In some cases, loss of a job or some other unanticipated crisis leads to eviction, then to doubling or tripling up with friends and relatives and, eventually, to the streets. In other cases, the inadequacy of welfare or pension benefits forces individuals or families to choose between necessities—paying the rent or putting food on the table—which leads to homelessness. Yet, whatever the variations in particular cases, certain common factors emerge as the major underlying causes of contemporary homelessness.

Scarcity of Affordable Housing

By far, the most significant cause of widespread homelessness is the increasing scarcity of affordable housing.[14] Over the past few years, large numbers of low-rent units in both the private and public markets have been eliminated. As a result, poorer Americans are now being squeezed out of their homes and onto the streets.

Until recently—and for the past 50 years—the federal government had consistently funded programs to ensure an adequate supply of affordable housing for low-income persons in the face of the inability of the private market to meet those needs alone.[15] While government subsidies for middle and upper income homeowners, in the form of mortgage interest deductions, have grown to $42 billion per year, funding for low-income housing programs has been reduced dramatically.[16] Since 1981, federal funds for subsidized and public housing programs have been cut by over 75 percent—from $32 billion per year to $7.5 billion.[17] As a result, throughout the country, waiting lists for these programs are years long; some studies have shown that almost two-thirds of American cities have closed their waiting lists.[18]

At the same time, local public and private activity has exacerbated the shortage. Unplanned development in the private housing market has replaced hundreds of thousands of low-rent dwellings with luxury apartments and office buildings. During the 1970s, such "gentrification" destroyed almost 50 percent of the nation's stock of single-room occupancy (SRO) units, traditionally a major source of low-rent housing. While urban renewal undoubtedly

produced some benefits, in too many cities development forces have created an unbalanced growth that has spurred the displacement of poor people to the streets.

Cutbacks in Service Programs

From 1980 to 1986, the national poverty rate has risen from 13 percent to 13.6 percent,[19] while federal spending on social services programs has decreased by 9 percent since 1981.[20] State spending, itself often inadequate, has failed to make up for the gap. Numerous studies have documented the relation between these data and homelessness.[21]

Aid to Families with Dependent Children (AFDC). AFDC is the major assistance program for poor families. Yet, since 1981, federal eligibility and payment standards have been tightened three times, removing large numbers of families from eligibility or reducing their benefits. These changes have resulted in a loss of over $3.6 billion from AFDC payments nationwide,[22] and have reduced the average monthly AFDC caseload by 442,000.[23] At the same time, AFDC levels—set by state governments—do not meet even minimum poverty standards. As a result, increasing numbers of families around the country are finding themselves unable to stretch their AFDC grants to cover rent and other basic necessities.

Food Programs. Reductions and changes in federal food programs have also contributed to the increasing inability of poor persons to meet basic needs. These changes not only lengthen the lines at soup kitchens but also force many poor people to make intolerable choices between necessities—such as food and shelter—that cause many to end up on the streets. Since 1982, $6.8 million has been cut from the Food Stamp program, pushing one million recipients off the program and reducing benefits for 20 million people, most of whom are children.[24] The average Food Stamp benefit is now 49 cents per meal.[25] In 1981, the federal Food Stamp outreach program was repealed.[26] In addition, state and local governments have often imposed permanent address requirements as a condition for aid. As a result, many poor persons—including large numbers of the homeless—are either unaware of or unable to apply for benefits.[27] Across the country, ignorance and bureaucratic obstinacy keep over 40 percent of the people eligible for Food Stamp benefits off the rolls.[28]

Disability Benefits. In 1981, the Social Security Administration adopted a program to review aggressively—and in many cases illegally—the receipt of disability benefits by elderly and disabled persons. As a result, by 1985, 491,300 recipients had been dropped from the disability rolls. Of those who were able to challenge the validity of these terminations, 200,000 were reinstated on appeal after lengthy administrative and court proceedings.[29] At least three cities—New York, Columbus (Ohio), and Denver—have documented the obvious causal connections between the resulting loss of benefits and homelessness.[30]

Unemployment

Increasingly, the country's homeless population is composed of the recently unemployed.[31] According to a 1984 survey, shelter providers across the country reported that 35 percent of shelter residents had become unemployed in the last nine months.[32] In a 1987 study prepared by the U.S. Conference of Mayors, 62 percent of the 25 cities surveyed cited unemployment as a major cause of homelessness.[33] A survey of homelessness in the Southwest found that, of seven Southwestern cities, six ranked unemployment as the most important cause of homelessness.[34]

In addition to unemployment, underemployment and low wages are now emerging as significant contributing causes of homelessness. About 20 to 30 percent of the homeless population now consists of working men and women who simply cannot make enough money to pay for an apartment or even a room.[35] The federal minimum wage, currently at $3.35 an hour, has not been increased since 1981, six years in which the cost of living has gone up 33.1 percent.[36] In some states, the minimum wage is even lower.[37] A low minimum wage, the elimination of federal job training and employment programs, and the dearth of adequate employment opportunities for unskilled persons, all contribute to the growing phenomenon of the working homeless.

Failure to Support Community Mental Health Services

Approximately 30 percent of the homeless population is mentally disabled.[38] The wave of deinstitutionalization that occurred from 1963 to 1980 is a component of this problem. From 1963 to 1980, the in-patient population of psychiatric institutions in the United States decreased from 505,000 to 138,000.[39] More significant, however, is the failure to provide mental health services for deinstitutionalized persons. Of 2,000 planned, federally supported, community mental health facilities, fewer than 800 actually were established.[40] Furthermore, states too often allow mentally ill persons to be discharged directly to shelters or the streets.[41]

Proper implementation of deinstitutionalization is clearly needed to address the problems of the homeless mentally ill. The difficulty is that deinstitutionalization has two parts: (1) patients must be discharged from asylums and (2) continued support must be provided in the community. The failure of deinstitutionalization is that, in too many

instances, the latter was not done. Yet, throughout the nation, there are scores of model programs where chronically mentally ill people live decently, fit harmoniously into a community, and require comparatively little public expense.

Government Response

The Inadequacy of Present Efforts

Current efforts to address homelessness are inadequate at every level. Virtually without exception, state and local governments are unable—in some cases, unwilling[42]—to address adequately even the most basic need for emergency shelter. According to a 1987 survey by the U.S. Conference of Mayors, an average of about 23 percent of the demand for emergency shelter goes unmet by local governments.[43] Significantly, the same survey identified homeless families as a specific group for whom shelter is "particularly lacking."[44]

Moreover, it is undisputed that, nationwide, the supply of shelter beds does not come anywhere near meeting the need for emergency relief. Even according to a report by HUD, existing beds in emergency shelters can accommodate fewer than half of the homeless on any given night.[45] In some parts of the country, the disparity is particularly acute. In Los Angeles, for example, the homeless population is estimated at 50,000, while there are fewer than 5,000 shelter beds.[46] Yet, despite the nationwide need, efforts to address the crisis have been woefully inadequate.

Solutions

In light of the basic characteristics and causes of homelessness, a rational legislative response should do three things. First, it should provide emergency relief to persons who are now homeless; that is, it should provide immediate survival resources. Second, it should prevent homelessness by providing assistance to persons who are now struggling at its brink. Third, it should provide long-term solutions by addressing the underlying causes of homelessness.

These three basic legislative objectives can and should be implemented by both the national government and state-local governments. There is often a debate as to whether homelessness is a federal or a local responsibility. In practice, this debate is largely irrelevant. Homelessness is now clearly a national problem, and the federal government should play a major role in addressing it. At the same time, however, the effects of homelessness are felt locally, and state and local governments should also play a role in responding. Indeed, given the inadequacy of the federal response, there is a dual role for local governments. First, state and local governments must provide emergency and long-term assistance. Model state legislation, described below, suggests specific steps that can and should be taken at the state and local levels. Second, state and local governments must also lobby the federal government for increased aid. In the final analysis, all levels of government must be part of an adequate response to homelessness.

Federal Legislation. Recommendations for federal action in each of the three main areas—emergency relief, preventive measures, and long-term solutions—are contained in the proposed "Homeless Persons' Survival Act." Drafted jointly by the National Coalition for the Homeless and ten other national organizations,[47] the act would provide for a comprehensive response to homelessness by the federal government. Initially introduced into the Congress in June 1986 by Rep. Mickey Leland (D-TX) and Sen. Albert Gore (D-TN), the bill now has over 70 cosponsors and is endorsed by more than 70 organizations. The annual cost of the bill would be about $4 billion. Highlights of the proposal are as follows:

1. *Emergency Relief.* Emergency measures would provide immediate relief to alleviate the suffering of those persons now homeless. These measures would:

- Establish a "national right to shelter." Federal law now provides emergency shelter to homeless families in 28 jurisdictions;[48] the provision should be extended to cover all homeless persons in all states. Funding would be 50 percent federal and 50 percent state and local.
- Provide effective outreach to all homeless persons for Food Stamp and SSI benefits.
- Eliminate current restrictions barring homeless persons living in shelters from receiving SSI benefits.
- Provide health and mental health care to homeless persons.
- Ensure access to education for homeless children.
- Modify the Food Stamp program to increase its accessibility to homeless persons.
- Create job training programs.
- Provide emergency assistance for homeless youth.

2. *Preventive Measures.* Preventive measures aim to halt the downward cycle to homelessness faced by families and individuals living on the margin of destitution. These measures would:

- Require local governments receiving federal funds to adopt ordinances designed to preserve low-rent units, such as SROs, and prevent unnecessary evictions from subsi-

dized housing by instituting procedural safeguards that must be followed before an eviction can occur.

- Provide temporary rental assistance to prevent evictions from private housing.
- Provide job assistance and, where necessary, provide jobs.
- Modify SSI rules to permit shelter residents and institutionalized persons to receive benefits.
- Modify AFDC "deeming" rules that now encourage the breakup of families and often precipitate homelessness.

3. Long-Term Solutions. Responsible long-term solutions to homelessness must address its major cause: an extreme scarcity of low-income housing. Such measures would:

- Increase funding for Section 8 certificates and moderate rehabilitation programs and increase the supply of public housing units.
- Develop community-based residences for the homeless mentally ill.

In pressing for passage of the Survival Act, the National Coalition has followed a two-part strategy. When the entire piece of legislation was first introduced in the House and Senate, the bill was also divided into subparts that could be enacted separately. In October 1986, several subparts became law.[49] In July 1987, much of the emergency portion became law in the form of the *McKinney Act*.[50] Portions of the preventive section also have become law.[51]

Yet, much remains to be done. While the *McKinney Act* provided some badly needed relief, even that emergency aid is now in jeopardy. Although the Congress authorized just over $1 billion in relief for 1987 and 1988, it actually appropriated only about $700 million.[52] In 1988 in particular, many of the programs were either drastically cut or actually eliminated because of the congressional failure to provide full funding. And unless the *McKinney Act* is reauthorized, even these resources will dry up in 1989.

At the same time that this emergency relief must be continued—and increased—longer-term measures must also be passed. In particular, passage of part three of the proposed Survival Act, which would provide permanent housing, is critical. In keeping with the two-part strategy, separate legislation embodying those provisions is now being prepared by the National Coalition for the Homeless.

State Legislation. Model state legislation patterned along the same three-part structure as the federal Survival Act is currently being drafted by the National Coalition. This model bill provides specific policy recommendations for state governments. Highlights of the bill include the following:

1. Emergency Relief. The bill would create, for each state, a right to emergency shelter. Such rights now exist in several jurisdictions.[53]

The bill would also create a statewide health and mental health care program to provide—either through local governments or through private non-profit organizations—health and mental health care directly at shelters and on the streets. The bill would amend existing state benefits programs to require outreach to homeless persons. Because they are isolated on the streets or in shelters, many homeless persons do not currently receive benefits to which they are entitled by law and which they desperately need. This provision would require the agencies responsible for the programs to send workers to shelters and soup kitchens to assist homeless persons in applying for aid. This would ensure that homeless persons entitled to assistance under existing programs actually receive it.

2. Preventive Measures. The bill would create a state-funded rental assistance program to provide temporary aid to families and individuals threatened with eviction—and homelessness—by an unexpected crisis. This section, patterned after an existing New Jersey statute, would be funded by state appropriations.

The bill would require local governments to enact controls to preserve existing low-cost housing, such as SROs.

The bill would create additional low-cost housing by mandating "inclusionary zoning", that is, in constructing private residential projects, developers would be required to create a certain proportion of low-income housing units. Such programs now exist in a number of cities, including Boston and San Francisco, and are required throughout New Jersey under the terms of the state's Supreme Court decisions.

The bill would prohibit the practice of "warehousing" by landlords. "Warehoused" apartments—typically low-rent units—are kept off the market by landlords seeking to empty a building so as to convert it into a cooperative or condominium. Especially in communities where there is a shortage of affordable housing, public policy should not permit landlords to hold scarce units hostage in order to later reap larger profits. Prohibiting this practice would make more low-cost housing available.[54]

The bill would increase state AFDC and General Assistance levels to meet minimum federal poverty standards. The bill would also raise state minimum wages.

3. Long-Term Solutions. The bill would create permanent housing for homeless persons funded through state appropriations as well as through housing trust funds. Housing trust funds, created by

the interest earned on real-estate related deposits, have been established in a number of states, including California, Connecticut, Florida, Kentucky, Maine, New York, and Rhode Island.[56]

Conclusion

Homelessness has now become a stark symbol of our nation's failure to meet even minimal standards of equity in the distribution of its abundant resources. Decisive action at all levels of government is urgently needed. While the need is great and the causes are deep, solutions to widespread homelessness do exist and must be implemented speedily. Both federal and local steps can and must be taken to address not only the symptoms but also the underlying causes of homelessness.

Endnotes

[1] For example, here are two local actions that deal more with symptoms than causes. In Los Angeles the Mayor instituted a "sweep" of the downtown area, driving homeless people out of that area and into an outdoor tent on the outskirts of the city. Santa Barbara enacted an ordinance prohibiting sleeping in public. This ordinance was specifically aimed at driving homeless people from the streets and—given the inadequate number of shelter beds—out of town.

[2] By 1984, several different organizations had estimated the total United States homeless population to be as high as 2 or 3 million people. For example, see U.S. General Accounting Office, Washington, DC, *Homelessness: A Complex Problem and the Federal Response* (hereinafter, "GAO Report") pp. 8-10 (1985); Hopper and Hamberg, *The Making of America's Homeless, 1605-1984*, Working Paper prepared for Community Service Society of New York, p. 8 (1984); Hombs and Snyder, *Homelessness in America* (Washington, DC: Community for Creative Non-Violence, 1982), p. ii. Following the wide dissemination of that estimate, the Reagan Administration commissioned a study that yielded an estimate of 250,000 to 300,000. Department of Housing and Urban Development, *A Report to the Secretary on the Homeless and Emergency Shelter Interagency* "HUD Report" (Washington, DC, 1984), p. 30. During a subsequent congressional investigation, this estimate was discredited by experts who testified that the HUD report had used a flawed methodology and had deliberately altered data in order to reach a low estimate. See *HUD Report on Homelessness: Joint Hearings before the Subcommittee on Housing and Community Development*, House Committee on Banking, Finance and Urban Affairs, and the Subcommittee on Manpower and Housing, House Committee on Government Operations, 98th Cong., 2d Sess. (Washington, DC: 1984).

[3] See U.S. Conference of Mayors, *The Continued Growth of Hunger, Homelessness and Poverty in America's Cities* (Washington, DC, 1987 (hereinafter, "Mayors' 1987 Report"), p. 21 (21% increase); National Coalition for the Homeless, *Pushed Out: America's Homeless, Thanksgiving 1987* (hereinafter, "Pushed Out"), p. iii (25% increase).

[4] *1933/1983—Never Again, A Report to the National Governors' Association Task Force on the Homeless* (hereinafter, "NGA Report") (1983) p. 18.

[5] *Pushed Out*, p. iii.

[6] For example, see City of New York, *Crisis Intervention Services, Monthly Report*, 11,447 children; 5,895 adults (January 88) p. 3.

[7] *Mayors' 1987 Report*, p. 21; *Pushed Out*, p. iii.

[8] For example, see, Robertson, *Homeless Veterans: An Emerging Problem* (unpublication draft on file at National Coalition for the Homeless); see also, National Coalition for the Homeless, Testimony before the Subcommittee on Education and Training, House Committee on Veterans' Affairs, September 30, 1986.

[9] For example, see *Mayors' 1987 Report*, p. 22; *NGA Report*, p. 29.

[10] *Mayors' 1987 Report*, p. 22 (22% employed).

[11] For example, see, *NGA Report*, p. 18.

[12] Enser, *Report to the Nassau Action Coalition* (1983).

[13] See National Coalition for the Homeless, *Rural Homelessness in America: Appalachia and the South* (November 1987); *Homelessness in America: Hearings before the Subcommittee on Housing and Community Development*, House Committee on Banking, Finance and Urban Affairs (1984) p. 148.

[14] For example, see, *Pushed Out*, p. iii; *Mayors' 1987 Report*, p. 24; House Committee on Government Operations, *The Federal Response to the Homeless Crisis, Third Report*, 99th Congress, 1st Session, pp. 3-4 (1985); *NGA Report*, pp. 36-40. Even the HUD report acknowledges the loss of low-rent housing units as a cause of homelessness. See *HUD Report*, p. 27.

[15] Cushing Dolbeare, "The Low Income Housing Crisis," in *America's Housing Crisis: What Is To Be Done?* ed. C. Hartman (1983) pp. 29-75; see also *Pushed Out*, p. 75.

[16] Low Income Housing Information Services (compiled from HUD Budget Summaries); *Pushed Out*, pp. 79-80.

[17] National Low Income Housing Coalition, *Graphs and Tables on Proposed 1988 Budget* (1987).

[18] *Mayors' 1987 Report*, p. 43.

[19] *The New York Times*, August 27, 1986.

[20] Center on Budget and Policy Priorities, *Smaller Slices of the Pie* (1985) p. 4.

[21] For example, see House Committee on Government Operations, *The Federal Response to the Homeless Crisis, Third Report*, 99th Congress, 1st Session, p. iii (1986); U.S. Department of Health and Human Services and Social Security Administration, *Social Security Information Items*, November 1986, p. 1.

[22] Based on information supplied by the Center on Budget and Policy Priorities.

[23] Children's Defense Fund, *A Children's Defense Budget* (1988) p. 144.

[24] *Ibid*, p. 182.

[25] Physicians' Task Force on Hunger in America, Harvard University School of Public Health, *Hunger in America* (1985) p. 9.

[26] The program was terminated in 1987 by the Stewart B. McKinney Homeless Assistance Act. Participation is voluntary, however; states receive 50% matching federal funds.

[27] Children's Defense Fund, *A Children's Defense Budget* (1988) p. 182.

[28] Statement from the Center on Budget and Policy Priorities, March 4, 1986.

[29] General Accounting Office, *Homelessness: A Complex Problem and the Federal Response* (hereinafter, "GAO Report") (1985) pp. 23-24.

[36] *Ibid.*

[37] *NGA Report*, pp. 32-35.

[38] *GAO Report*, p. 39.

[39] *Mayors' 1987 Report*, p. 25.

[40] *GAO Report*, p. 39.

[41] *Mayors' 1987 Report*, p. 22 (22%).

[42] Telephone conversation with Mr. Russell, Public Information, U.S. Department of Labor, 4/2/87.

[43] For example, in Seattle, it is only $2.25/hour.

[44] *NGA Report*, p. 43.

[45] Ibid, p. 41.

[46] *GAO Report*, p. 20.

[47] For example, see, Klostermann v. Cuomo, 61 N.Y.2d 525, 463 N.E. 2d 588 (Sup. Ct. N.Y. Co. 1984).

[48] Some local governments have responded by attempting to drive the homeless out of town. For example, Santa Barbara issued an ordinance prohibiting sleeping in public specifically aimed at homeless persons, while downtown Atlanta efforts are underway to establish a "vagrant" free zone.

[49] *Mayors' 1987 Report*, p. 33.

[50] Ibid, p. 34.

[51] *HUD Report*, p. 34.

[52] *Pushed Out*, p. 30.

[53] The ten organizations that drafted the Homeless Persons' Survival Act with the National Coalition were: National Housing Law Project; National Low Income Housing Coalition; National Mental Health Association; Mental Health Law Project; Food Research and Action Committee; Children's Defense Fund; Center on Law and Education; Institute for Policy Studies; National Senior Citizens Law Center; Committee for Creative Non-Violence.

[54] Federal law provides emergency shelter to homeless families in California, Delaware, the District of Columbia, Georgia, Illinois, Kansas, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming, Puerto Rico, and the Virgin Islands.

[55] These subparts barred permanent address requirements for the AFDC, SSI, Medicaid, and Veterans' Benefits programs; created a "pre-release" procedure for institutionalized persons to apply for SSI benefits; included homeless persons in the Job Training Partnership Act; and permitted homeless persons to use food stamps to obtain prepared meals from nonprofit eating establishments.

[56] The right to shelter provision was not included in the *McKinney Act*; however, the new act created an emergency shelter grants program and a transitional housing program.

[57] The Supplemental Security Income (SSI) amendment, Public Law 100-203 (1987), the *Omnibus Budget Reconciliation Act of 1987*. The anti-displacement amendment sponsored by Rep. Barney Frank, Public Law 100-242 (1988), the *Housing and Community Development Act of 1988*. It may also be cited as 100 Stat. 1815 (1988).

[58] The following table illustrates the disparity between authorizations and appropriations for 1987 and 1988.

STEWART B. McKINNEY HOMELESS ASSISTANCE ACT
Appropriations Compared to Authorizations
(millions of dollars)

	Authorized by: PL 100-77 for 1987	Appropriated for 1987	Authorized by: PL 100-77 for 1988	Appropriated for 1988
HUD-Independent Agencies				
[illegible]	$15	$10	$124	$114
[illegible]	100	50	120	8
[illegible] ration Program	80	80	100	65
[illegible] the Homeless	25	15	25	0
[illegible] Occupancy Dwellings	35	35	35	0
[illegible]	0.2	0.2	2.5	*
[illegible]	20	20	0	0
Subtotal	$275.2	$210.2	$406.5	$187.0

*[illegible] Supportive Program.

Labor-HHS Education				
[illegible]	$50	$46	$30	$14.361
[illegible] Services for the Homeless Block Grant Program	35	32.2	such sums as may be necessary	11.489
[illegible]	10	9.3	0	0
[illegible]	10	9.2	0	0
[illegible]	5	4.6	7.5	4.787
[illegible]	7.5	6.9	10	7.18
[illegible]	40	36.8	40	19.148
[illegible]	0	0	2	1.915
[illegible]	0	0	10	7.659
Subtotal	$157.5	$145	$99.5	$66.539

	Authorized by: PL 100-77 for 1987	Appro-priated for 1987	Authorized by: PL 100-77 for 1988	Appro-priated for 1988
Department of Agriculture				
Temporary Emergency Food Assistance Program	$0	$0	$50	$50
Food Stamp Shelter Deduction	0	0	36	36
Food Stamp Household Definition	0	0	15	15
Food Stamp Outreach	0	0	1	1
Food Stamp Vendor Payments	0	0	7	7
Food Stamp Eligibility Update	0	0	-2	-2
Food Stamp Earned Income Deduction	0	0	-3	-3
Surplus Food Distribution	0	0	6	6
Subtotal	$0	$0	$110	$110
Total	$432.7	$355.2	$616.0	$363.539

[53]For example, New York City; West Virginia; Atlantic City, New Jersey; California; Washington, DC; and St. Louis, Missouri.

[54]See Coalition for the Homeless, *Warehoused Apartments/ Warehoused Lives* (1987).

[55]See, e.g., National Association of Housing and Redevelopment Officials, *New Money and New Methods: A Catalog of State and Local Initiatives in Housing and Community Development 1979-1986*, p. 11.

Housing Trust Funds, created by the interest earned on real estate-related deposits, are a potential source of revenue for low- and moderate-income housing. State legislation is required to implement such a program. The Housing Trust Fund formula is based on the successful Lawyers' Trust Accounts (IOLTA) program that finances legal services to the poor.

Potential Housing Trust Fund revenue sources include a wide array of real estate-related transactions including: escrow deposits; real estate title transfer fees; mortgage property tax and property insurance prepayments; commercial and residential tenant security deposits; water, sewer, and public utility deposits; rural electric cooperative deposits; state escheat funds and municipal surety bond deposits.

The *Wall Street Journal* estimates that nationwide income from tenant security deposit and sale and mortgage escrow interest could total $1.7 billion annually, enough to build 39,000 units, or moderately rehabilitate 170,000 units.

Legislation was introduced in at least eight states as of 1985: California, Delaware, Illinois, New York, New Jersey, North Carolina, Oregon, and Washington. Other states considering trust funds are Florida, Massachusetts, Michigan, Nebraska, North Carolina, and Ohio.

Seven states have been using HTF's for the last three years:

- *California* (1985)—offshore oil revenues
- *Connecticut* (1986)—Contributions of state business generated by deductions and tax credits from state corporate taxes
- *Florida* (1983, 1986)—Surtax on deed transfers from sale of property—Dade County (1983); State (1986)
- *Kentucky* (1985)—Surplus funds from previous bond issues of the Kentucky Housing Corporation
- *Maine* (1985)—Real estate transfer tax
- *New York* (1985, 1986)—Appropriations from the General Fund for two new Trust Funds.
- *Rhode Island* (1986)—Credit reserves of the Rhode Island Housing and Mortgage Finance Corp.

Ohio's Coordinated Response to the Problems of Homelessness

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Homelessness emerged into the national consciousness as a major social problem in the 1980s.[1] The increasing numbers of people on the streets prompted federal, state, and local officials to gain an understanding of both the causes of homelessness and the prevalence of various types of problems within the homeless population. Studies were commissioned in a number of cites because local officials felt the need for a knowledge base from which to work in planning and developing programs to address the problem.[2] In a parallel development, the National Institute of Mental Health funded a number of studies with a more national focus, many of which gave special attention to issues surrounding mental illness and homelessness.[3]

Hence, by 1985, a body of new knowledge about the problems of homeless individuals was available to policymakers. This paper examines Ohio's research and the resultant policy and program development, and describes the Cabinet Cluster on Homelessness, convened by Governor Richard F. Celeste to organize activities on behalf of homeless people.

An Initial Study Creates Awareness in Ohio

Methodology

In 1984, the Ohio Department of Mental Health (ODMH) completed a comprehensive study in which 979 homeless persons were interviewed in 19 counties over a six-month period. The counties were selected in a stratified random sample to include major urban areas, small-city areas, and rural areas. Homeless respondents were classified according to the type of homeless condition in which they had slept the previous night. For sampling purposes, four levels of homelessness were established: (1) limited

or no shelter (e.g., under bridges, in cars, etc.); (2) shelters or missions for homeless persons; (3) cheap hotels or motels if actual length of stay or intent to stay was less than 45 days; and (4) unique situations, such as living with friends or relatives on a very short-stay basis. Within these conditions, interview sites were varied, and interviewers were taught to use random selection procedures when possible. Questions in the survey instrument addressed reasons for homelessness, current living arrangements, migration patterns, employment history and income, contact with family and friends, history of psychiatric hospitalization, use of social services, medical problems, general well being, and demographic information. In addition, a mental status examination was done with each interviewee to assess current mental health status and level of psychiatric symptomatology.

Ohio was an excellent setting for this study because the state is very similar demographically to the United States as a whole. Ohio's total 1980 Census population of 10,797,419, the sixth largest state in the nation, was distributed across 88 counties ranging in size from Cuyahoga County with 1,498,295 to Noble County with 11,584. The state is close to the national average on the mix of rural/urban population and in the distribution of race, age, education, and income. Further, Ohio is a state undergoing significant changes, both in its economic base and in its population distribution and composition. The state is experiencing, first-hand, many of the forces and policies that have been purported to be related to the condition of homelessness, such as poverty, plant closings, unemployment, and the destruction of low-income housing.

Findings

Of the 979 homeless individuals interviewed, 81 percent were male and two-thirds were white. Nearly half were single; 43 percent were separated, widowed, or divorced; and the median age of the group was 34. More than half had not graduated from high school; three-quarters had been homeless for less than a year; and 58 percent said they had been in jail or prison.

Many of the stereotypes of homeless people were not supported by study findings. Our group was less mobile—most had stayed in two or fewer places in the past month—and less transient than might have been expected: 64 percent had either been born in the county in which they were interviewed or had lived there longer than a year. Most (87 percent) had worked at some point in their lives, and a quarter had worked for pay in the past month. Nearly half of those who had been employed in the past but were not working now said that they had looked for a job but had been unable to find one. Almost two-thirds had some source of income in the past month, primarily from welfare, earnings, or Social Security. The picture that emerged was one of a largely indigenous population of individuals who were not totally without funds but whose income was not sufficient to pay for permanent housing.

After hearing at length from nearly 1,000 homeless people across Ohio, economic factors emerged as a primary theme. For half the group, economic reasons were the major cause of their homelessness, and nearly one-quarter cited family conflict as the reason they were without a home.

In addition to their lack of housing, jobs, and resources, homeless people had a variety of other problems. Only a third (36 percent) said they had relatives they could count on for help, and only 41 percent said they had friends they could count on for help. A third of the sample had physical health problems, and an almost equal percentage (31 percent) had psychiatric problems. Thirty percent had had a psychiatric hospitalization in either a public or private facility. Well over half (64 percent) said they had been drinking either some or a lot in the past month, and 27 percent indicated that they had sought help for a drinking problem at some point in their lives.

Differences were found between urban and nonurban (those from mixed and rural counties) homeless groups on some of the study variables but not on others. While nearly half of both groups cited economic reasons as the primary cause of their homelessness, family problems were a greater cause in nonurban areas (29 percent) than in urban areas (20 percent). Respondents in the urban counties (42 percent) were far more likely to report that they were born in the county in which the interview took place than were respondents in nonurban counties (29 percent).

A high percentage of both urban and nonurban homeless people had held a job at some point in their lives, but nonurban respondents were more likely (33 percent) than urban respondents (22 percent) to have worked for pay in the past month. For those not now working, 62 percent of nonurban people and 44 percent of urban people said they had looked for work but were unable to find a job. Nonurban respondents were more likely (79 percent) than urban respondents (60 percent) to report having had income in the past month. Welfare and earnings were the major sources of income for both groups.

There were substantial differences evidenced in social support networks. Nonurban homeless people were 10 percent more likely to say that they had relatives they could count on and 20 percent more likely to say that they had friends they could count on for help. Nearly one-quarter of urban homeless people said they had no relatives, in contrast to 10

percent of nonurban homeless people. Rates of physical health problems, psychiatric problems, and psychiatric hospitalization did not differ substantially, but urban respondents were somewhat more likely to report problems with alcohol use.

Three distinct types of homeless people emerged out of the data analysis: street people, who do not use shelters; shelter people; and resource people, who do not use shelters and are able to stay in cheap hotels or with family and friends for short periods of time. Resource people were found to have been homeless for a shorter period of time (median of 35 days) than street people (median of 60 days) or shelter people (median of 90 days), but there were no substantial differences across groups in their reasons for homelessness.

Over 90 percent of the shelter people had a job at some point in their lives, compared to 82 percent of the resource people and 78 percent of the street people. While two-thirds of the overall homeless group said that they had income during the past month, there were differences in percentages among street people (50 percent), shelter people (63 percent), and resource people (74 percent). The major sources of income for all groups were welfare and earnings.

In the area of social support, there were only small differences among the three types of homeless people. Small differences were recorded in percentages reporting health problems and psychiatric hospitalization, but there were no differences in levels of psychiatric problems across the three types. More street people reported alcohol use, but shelter people (32 percent) and street people (26 percent) indicated that they had sought help for a drinking problem more than resource people (12 percent).

The results depicted in Table 1 illustrate (1) that homelessness is a complex, multi-faceted issue, (2) that homeless people have a variety of problems, and (3) that this multiplicity of problems needs to be addressed in order for appropriate governmental response and service strategies to be developed.

Organizing for Action in Ohio

The preliminary results of the research were presented to Ohio Governor Celeste in a private briefing with a few key cabinet officials in late 1984. His response to the study's primary finding about the

Table 1

Problems of Homeless People in Ohio

Area	Percent Reporting Problems
Housing	100.0
Employment	
No work for pay during last month	75.3
Looked, could not find work	29.5
Disabled, could not work	13.0
Do not want to work	3.0
Not job ready	5.0
Social Support	
No relatives, or cannot count on relatives	64.2
No friends, or cannot count on friends	58.1
Neither friends nor relatives, or cannot count on friends or relatives	43.1
Income	
No income at all during past month	36.6
Welfare as major source of income	23.8
Problems paying rent as major reason for homelessness	13.9
Alcohol/Drug Abuse	
Reported alcohol use	64.2
Both alcohol and drug or medication use	39.2
Reported having sought alcohol treatment	26.6
Any type of drug or medication use	32.2
Probable alcoholism	20.8
Mental Health	
Psychiatric symptom presence requiring service	30.7
Unmet needs for mental health services	24.3
Physical Health	
Any type of physical health problem	30.7

multifaceted nature of the problem was to develop a multifaceted structure to address it.

Inception of the Cabinet Cluster

The governor asked the director of the Department of Mental Health to chair a Cabinet Cluster on Homelessness. The Cabinet Cluster would include directors of the Departments of Health, Mental Retardation and Developmental Disabilities, Rehabilitation and Corrections, Aging, and Human Services, as well as administrators of the Bureau of Employment Services, the Rehabilitation Services Commission and the Ohio Housing Finance Agency, and representatives of the governor's offices of Advocacy for Recovery Services, Advocacy for Persons with Disabilities, and Criminal Justice Services. The Cluster concept brought together decisionmakers responsible for all the service areas indicated by the study as being needed by homeless people. It was a positive approach that avoided blame and instead focused attention on short- and long-term solutions.

Dissemination of Study Results

The first task of the Cluster was to present study findings to the media and to their constituencies in a way that emphasized the complex nature of the problem. A press conference was called by Governor Celeste, with all of the members of the Cabinet Cluster in attendance. The results of the study were presented, and the formation of the Cluster was announced, along with its charge to develop coordinated approaches to the problems of homelessness. Just prior to the press conference, study results were shared with key members of the legislative leadership as well as legislators whose counties had been involved in the study.

The dissemination of study results to the human services system and to the general public was seen as an important tool in beginning to seek solutions to the problem. The final report of the research was completed early in 1985, and five regional workshops were held around the state. During each day-long workshop, statewide study results were presented in the morning. The afternoon session was different in each location; it started with a presentation of the study results for that geographical area, and then shifted to a discussion among participants about actions which should be undertaken by various local groups and organizations to address the problems of homeless people in their respective communities. The participants who were invited to the workshops represented a wide range of affiliations and interests in each of the local communities, mirroring the service needs the study results showed to be important for homeless people. The Cabinet Cluster members assisted in the dissemination workshops by seeing that their local counterparts attended the workshops, thereby guaranteeing that all the appropriate service systems would be represented in the discussion. In a surprising number of instances, workshop participants indicated that the agencies and organizations in the room had never before gotten together to discuss community problems which affected all of them.

Governor Celeste assisted further in dissemination efforts by using the study results for discussion at a meeting of Ohio's congressional delegation. As a direct result of that education, state Department of Mental Health staff were invited to testify before Congress several times on issues relating to homelessness and housing. ODMH staff also presented the research results at the 1985 summer meeting of the National Association of State Mental Health Program Directors in Washington. Out of that meeting came the beginnings of a process that resulted in position papers from the association on homelessness and on community support services for persons with long-term mental illness.

Involvement of the Ohio General Assembly

In the winter of 1985, the issue of state assistance for shelters became a focus of legislative interest, in part due to the dissemination of study findings and in part due to advocacy at the state level by local homeless shelters. Legislation was introduced to provide state dollars for community shelter operations that could produce local matching funds. As a reflection of the findings of the study and the Cluster's existence, legislation was enacted with a provision that at least 30 percent of each grant had to be spent on services that would address the problems and needs of homeless people, rather than on operating expenses of the shelters.

Ongoing Work of the Cluster

After assisting in the dissemination of the research findings, the Cluster concentrated on the other components of Governor Celeste's charge: achieving a shared understanding of the services already available to homeless persons through the various state agencies, undertaking new initiatives to address the problems of homeless people, and making recommendations to the governor about possible actions and policies. The group met frequently for several months, and most departments developed at least one demonstration project to assist homeless people and sought to raise the level of visibility of homelessness as a state issue. By mid-1985, the Cluster reported that the following actions had been taken by state agencies:

1. The Department of Human Services approved a waiver to existing Title XX regulations. The waiver permitted more than one information and referral provider per

county, thus allowing shelter operators to be information and referral providers.

2. The Department of Human Services issued a policy clarification on Food Stamp benefits stating that residents of "open" shelters met the federal residency requirements and were potentially eligible to receive Food Stamp benefits. The department also clarified the policy on general relief to ensure that people without permanent residence were not excluded from receiving general relief.

3. The Department of Development and the Ohio Housing Finance Agency had taken major actions, among which were:

   a. Reactivated the "Seed Money" Loan Program, giving it a clear emphasis on low- and-moderate income housing. This program provides interest-free loans to nonprofit, limited-profit, or public housing sponsors to cover up-front costs related to obtaining financing for low- and moderate-income housing developments, thereby stimulating increased production of low-rent housing.

   b. Proposed a new competitive grant program for community-based, nonprofit groups to produce local housing development projects in the Department of Development's FY 1986-1987 budget request. If approved, eligible organizations could apply for grants up to $50,000 for up-front project packaging and direct capital investment. Projects needed to benefit low- and moderate-income residents of a defined geographic area. It was anticipated that several proposals would be for low- and moderate-income housing development and would be used to leverage other public and private funds.

   c. Developed a Rental Housing Advisory Group, to make recommendations for actions to increase the supply of affordable rental housing.

4. The Ohio Department of Aging and the Ohio Housing Finance Agency developed an Elderly Housing Task Force that focused on four areas: (a) programs to help elderly homeowners convert their home equity to income; (b) making housing rehabilitation and energy conservation resources more readily available to older persons; (c) protecting consumers of life care or contract care housing for elderly persons; and (d) examining other program options that would serve low-income older people's households.

5. The Rehabilitation Services Commission, through the Bureau of Disability Determination, made arrangements for St. Paul's Community Center in Toledo to have an SSA Field Representative on site once a month for three hours to take applications for SSDI benefits as a pilot project.

6. The Department of Health, along with the Department of Mental Health, participated in preparing proposals for health care for homeless persons to The Robert Wood Johnson Foundation.

7. The governor's office of Criminal Justice Services planned with the Department of Mental Health to review research literature on persons in jails having mental health service, housing, and other support needs.

8. The Ohio Bureau of Employment Services was in the planning stage for a demonstration project in Columbus that would provide job order information to shelters, train shelter staff to use microfiche information to make shelter users aware of available jobs, designate contact people in local offices that shelter staff could call to request referral for residents for jobs listed in microfiche, do on-site assessment of shelter residents for job training needs; and make referrals to the local JTPA office for those residents assessed by OBES as ready for job training.

9. The Department of Mental Health, through grants to local community mental health boards, made available matching dollars for outreach, case management, and cooperative housing and rehabilitation programs for homeless persons who are mentally ill. Up to $1,000,000 was planned to be allocated for these endeavors. The department also completed an application to the National Institute of Mental Health for a mental health service demonstration project for homeless persons, which was subsequently funded. In addition, a statewide Mental Health Housing Task Force jointly staffed by the department and the Ohio Housing Finance Agency was in operation and was preparing to advise the director of the Department of Mental Health, the governor and others on housing needs in the areas of licensure, program, and financing requirements for mentally ill Ohioans.

In addition to summarizing actions being undertaken by all state agencies, the 1985 Cabinet Cluster

report to Governor Celeste recommended the following action steps:

1. Develop a strong public-private partnership at the federal, state, and local levels to bring all resources to bear to reduce the problems of homeless or potentially homeless persons. The state must take a major leadership role to effect such a partnership including private and volunteer organizations, and city, county, state, and federal governments.

2. Explore the possibility of utilizing Adult Emergency Services funds from the Ohio Department of Human Services to assist shelters in providing services to homeless people.

3. Recognize the need for increased services for homeless and about to be homeless persons. Increased services that are being addressed by the Cluster include the availability of housing, health, and mental health care, and vocational programs or jobs. Each Cluster agency is in the process of identifying new or modified initiatives. The Cluster also recognizes that many services are initiated and carried out by federal agencies. The Cluster urges the governor and Cluster agencies vigorously to oppose federal cuts for housing programs and basic subsidies for persons with limited or no income. President Reagan's current budget recommendation would drastically reduce or totally eliminate much needed low-income housing programs.

4. Recognize the need to modify and refine policies that may prohibit or make access to basic services difficult. Such policies include but are not limited to rules on using a shelter as an address or policies that would improve access to jobs and vocational rehabilitation.

5. In line with improved policies, require state-level cooperation in order that policy and program development is consistent across departmental lines; that new initiatives are developed across department lines when combining resources to maximize the impact of the assistance to be provided; that information on state-level initiatives be disseminated as broadly as possible, and to serve as a vehicle to bring together statewide advocacy groups, professional organizations, business leaders, and others to bring all resources to bear to reduce the problems of homeless or potentially homeless persons.

6. Encourage the portrayal of the problem of homelessness using the most accurate and complete data. The federal government has insisted on portraying homeless persons as largely being mentally disabled and alcoholic persons. The Cluster urges a more accurate and more sophisticated view.

The data from Ohio's study and other studies of homelessness give a clear picture of homeless people. They are persons who do not have permanent shelter, jobs or sufficient income, and to a lesser degree have problems with family relationships, and have mental health, health, and substance abuse problems. Persons who are homeless are disproportionately young, black, and male. Comparisons of homeless persons in rural and urban areas indicate that the types of homelessness and the resources that can be accessed differ.

The Cluster recommends, therefore, that both the governor and the members of the Cluster urge federal officials, as well as other state and city officials, to present an accurate portrayal which includes these and other facts, so that suggested remedies to the problem can be made in a responsible fashion, based on fact rather than myth.[4]

During 1986, the Cabinet Cluster met less frequently, but it remained a vehicle for interdepartmental communication about homeless issues. The group received updates about programs going on in various departments and reviewed the implementation of the shelter grants program authorized a year earlier by the legislature. The program was administered by the Department of Health, and utilization data for the first year were used by the Cluster to estimate the need for funds in upcoming years. The group did spend considerable time discussing possible recommendations to the governor regarding a shelter assistance line item in the next biennial budget. A fundamental debate permeated those discussions regarding the role and the ultimate effect of providing more shelter beds for homeless people. On the one hand, greater levels of need were clearly obvious from Health Department reports and other sources. On the other hand, a number of Cluster members were concerned that a focus on shelters, both in the minds of legislators and in the eye of the public, would detract from work on the kinds of long-term solutions that are really needed to address the multiple problems of homeless people. The subsequent budget did contain an increase for shelters; however, the debate among Cluster members over the amount of effort that should be spent on temporary versus more permanent solutions has continued as a source of tension in overall state housing discussions.

Homelessness and State Housing Policy

In early 1986, the Ohio Mental Health Housing Task Force released its final report defining housing

problems and needs of persons who are mentally ill. The task force was co-chaired by a nationally known architect/researcher and by the deputy director of the Ohio Department of Development, and included representatives from the mental health system, rehabilitation and housing agencies, home operators, government officials, community and advocacy groups, mental health service consumers and family members, and other state agencies.

The task force report identified the lack of decent, affordable housing as a major issue for severely mentally disabled individuals in Ohio, most of whom are poor. It developed 49 recommendations in four major areas:

1. Increase the personal and housing resources available to mentally disabled community residents.
2. Improve the quality of existing housing.
3. Do a better job of serving the special needs and wishes of mentally ill community residents.
4. Extend housing and housing services to people not being served, wherever they are living.[5]

In part as a result of this report and in part out of the debate within the Cluster over the effect of funding shelters, the Cluster began examining the state's role in low-income housing development. By this time, the Cluster meetings were often attended by the governor's executive assistant for Human Services, and the Office of Budget and Management's (OBM) Human Services budget analyst. The idea for a Housing Trust Fund was developed by the Ohio Housing Finance Agency (OHFA), and the staff members from OBM. In addition, the governor's office played a key role in getting the idea considered in the budget planning process.

While the Housing Trust Fund idea was not pursued due to lack of a funding source, it became apparent that state leadership was essential in addressing low-income housing needs. The result has been ongoing work between ODMH, OBM, OHFA, and the governor's office on ways to bring state capital dollars, private financing, federal and local community dollars, and the state housing authority together in ways that assist low-income normalized housing to be developed, with all or part of the housing units dedicated to mental health use. In order to accomplish this objective, both Department of Administrative Services rules and processes and ODMH rules and processes are being waived or abbreviated to facilitate the development of housing projects. Not only does this cooperative approach cut through red tape in order to get low-income housing developed, but it also revitalizes community neighborhoods and supports the concept of normal housing for persons with long-term mental illness.

Continuing Cluster Operations

The Cabinet Cluster became more active in 1987, in part due to the advent of the United Nations International Year of Sheltering the Homeless, and meetings took place to focus on ways in which Cluster members and public officials, including the governor, could be involved in honoring the year and keeping the issue in the public eye. In the summer, the Cluster decided to take research and policy results about homelessness to the state's most public, high-volume event of the year: the Ohio State Fair. A booth was jointly funded by Cluster agencies. The exhibits featured the research findings, stories about Ohio's homeless people, and information about the efforts of various state agencies to deal with the problem.

Evaluation of the Ohio Experience

The Ohio experience illuminates several benefits of interagency and interorganizational coordination. It also suggests some potential pitfalls to avoid. These factors are evaluated next.

Benefits of Interagency and Interorganizational Coordination

In addition to the benefits from intergovernmental and interagency coordination, the Cluster provided a ready-made vehicle to coordinate development of the proposals necessary to apply for monies under the *Stewart B. McKinney Homeless Assistance Act of 1987* (*McKinney Act*). Although no mechanism and no funds were provided to coordinate state and local agencies, provisions of the act required that states prepare a Comprehensive Homeless Assistance Plan (CHAP) in order to be eligible to apply for and receive funds under Title IV, HUD-administered funding, which includes the Emergency Shelter Grant program, Supportive Housing Demonstration Programs, Supplemental Assistance for Facilities to Assist the Homeless, and Section 8 Single Room Occupancy (SRO) Moderate Rehabilitation Assistance. According to HUD guidelines, the CHAP needed to include:

1. Documentation of the state's need for assistance in areas mentioned above, as well as literacy training;
2. An inventory of facilities, services, and programs for homeless persons within the state; and
3. A strategy to match needs with services and to avoid duplication;
4. Projected impact of the anticipated *McKinney Act* monies.

The Cluster established a working group to guide the development of the CHAP and, subsequently, to

coordinate receipt and expenditure of *McKinney Act* funds. In formulating the membership of this group, there was an attempt to mirror the Interagency Council at the federal level and to anticipate those agencies that would be responsible for carrying out activities under the various sections of the act. Hence, representatives from the Department of Education, the Veterans Administration, the Department of Development's offices of Local Government Services and Community Services, the Bureau of Employment Services Office of Adult Literacy Services, and the Ohio Coalition for the Homeless were added to the group. This group also included representatives from the Cluster agencies of the Department of Health, Department of Mental Health, Ohio Rehabilitation Services Commission and the Department of Development's Ohio Housing Finance Agency.

Primary writing responsibility for the CHAP document was assigned to the Department of Development, as lead agency to implement HUD-related McKinney programs. Results of the research were heavily used in documenting the needs section, and the draft CHAP was reviewed by the Cluster prior to its submission. It was subsequently approved by HUD.

Ohio's overall strategy for use of *McKinney* funds, in combination with its own efforts to address the needs of homeless people, was outlined in the CHAP as follows:

1. Coordinate the development of networks of housing programs in order to utilize fully federal assistance as well as state assistance and programs, together with local or private assistance.

2. Create a work group of the Cabinet Cluster on Homelessness with an enhanced membership to coordinate receipt and expenditure of *McKinney Act* funds and to address additional service needs of homeless people.

3. Encourage development or expansion of local homeless coalitions, interagency councils, and similar groups to include all public and private organizations who are involved or should be involved in providing services to homeless people in the area. Provide consultation and assistance to local groups to enhance program development and administration.

4. Review existing guidelines of the various state departments administering state and/or federal assistance programs to assure that all grantees demonstrate how the grantee is networking with other providers of services to homeless persons in the area.

5. Review applications for funding through the *McKinney Act* certifiable by the State of Ohio as being consistent with the CHAP, with particular regard to the need for local coordination and negotiation to ensure that services fit the needs of homeless persons.

6. Encourage the development of projects which recognize the special needs of homeless people who are veterans, elderly, families with children, or mentally ill.

7. Prepare through the Cluster work group an annual report which will review and assess existing programs and those created under the *McKinney Act* in terms of ways in which they have addressed the needs of homeless Ohioans. This report will also include the state's progress in carrying out the CHAP. Findings and recommendations for policy changes will be given to the appropriate state and federal agencies, including the Secretary of HUD.

8. Recognize the critical importance for the development of a spectrum of housing options to meet the needs of homeless Ohioans, and charge the Homeless Cluster with adopting a strategy outlining ways for Ohio to enhance efforts to provide emergency shelter, transitional housing, and permanent affordable housing as well as required supportive services.

9. Expand required coordination criteria in the *Job Training Partnership Act* (JTPA) to include the Departments of Health, Mental Health, Development, and any other department responsible for carrying out part of the *McKinney Act*.

10. Design Job Training Demonstration Programs to include outreach to homeless persons, provide employment and training services in collaboration with organizations giving health and housing services, show networking with other agencies, and provide sufficient services to ensure that homeless people complete training or job preparation and enter employment.[6]

In addition to activities in response to the *McKinney Act*, state officials have been active in the national arena on issues related to homelessness. Ohio's state housing policy approaches and concerns will be discussed in 1988 by the director of the Ohio Department of Mental Health, who will join ten other state mental health directors as a National Association of State Mental Health Program Directors work group on housing issues. The work group will develop recommendations to the states and will draft official position statements for the national

association to consider regarding federal housing policies.

Potential Pitfalls in Interagency Coordination

Policymakers need to be aware that a number of difficulties may arise in the course of developing and implementing an interagency coordinating mechanism. If there is not at least some minimal funding for the group's operations, the initial level of enthusiasm may fade in the face of the practical difficulties of finding meeting space and securing staff support. After the group gets under way, there may be differing levels of commitment to the problems of homeless people and to putting in the time to make the interagency mechanism successful. Similarly, philosophical differences may arise among members regarding the roles of their agencies vis-a-vis homeless people, or, as discussed above, regarding the appropriate role of state government in long-term solutions such as low-income housing.

Clear direction for the state policymakers as a whole must come from the governor's office, with a clear mechanism to resolve policy or philosophical disputes among or between agencies. Establishing a lead agency and a governor's office liaison may help to keep the common goal in front of the interagency group as a whole. If state monies are appropriated for shelters or services for homeless people, political issues may arise over which department should receive and administer the funds. Genuine coordination of services among different agencies, which have different and perhaps even conflicting rules and procedures concerning access to their services, is a difficult and often frustrating task. However, it offers the best hope for recognizing the multifaceted nature of the homelessness issue and for developing the kind of service system that homeless people need.

Conclusion

The State of Ohio has made extensive use of research results to strengthen its policies and programs serving the homeless. The research showed homelessness to be a complex, multifaceted issue, and this major finding was emphasized both in dissemination efforts and in the interagency structure established by Governor Celeste to seek coordinated short- and long-term solutions to the problem. The Homeless Cabinet Cluster has been an enduring and useful mechanism to achieving overall coordination of state agency efforts on behalf of homeless persons. It provided a ready-made vehicle to coordinate development of applications for funds under the *McKinney Act*, and it will have a major role in implementing and monitoring programs created under that act.

In order for states to address meaningfully the problems of their homeless citizens, several factors need to be present: public awareness of homelessness as a complex problem with multiple causes; commitment to the issue and leadership by the governor in pursuing solutions; an interagency mechanism to coordinate activities and programs; and a statewide focus on a range of strategies to address the problems of homelessness, particularly those which offer hope for more long-term solutions.

Recommendations

The Ohio experience suggests that other states should consider the following seven types of action:

1. Public Awareness. The state should increase public awareness of the problems of homelessness. Use research such as the Ohio study to emphasize the complex, multiproblem nature of homelessness. Talk about research results and other data in public forums designed to bring different segments of a local community together to work on solutions rather than just listen to information. Build on the media interest in homelessness to emphasize the diverse nature of the homeless population and to encourage media discussions of more long-term solutions. Capture media interest with the governor's presence at exemplary programs which focus on long-term solutions (permanent housing, jobs, etc.).

2. Treat Causes. The state should not deny the connection between homelessness and mental illness, or between homelessness and alcoholism. However, focus on the mental health needs of mentally ill homeless men, women, and children and the extraordinary poverty and stigma faced by mentally ill people in general. Concentrate efforts on services and solutions (e.g., supported housing, case management, job training, alcohol and other drug abuse services) rather than on dissecting past policies that may or may not have been to blame for homelessness and which, in any case, are probably not now reversible.

3. Gubernatorial Leadership. The governor's office should exert leadership that avoids blaming any sector of the service system for the problem and sets the expectation that all agencies need to be involved in creating solutions. The most critical component in a successful and coordinated approach to homelessness at the state government level is a very clear and forceful message from the governor about what he or she expects. Part of this message should be continuing access to the governor and to his or her staff for assistance in solving cross-agency problems.

4. Parallel Local Efforts. Encourage parallel mechanisms at the local level. Use any housing or related service funds the state has available to require the development of local coordinating bodies as a condition for receiving state funding. Require local matching monies, but be flexible so that private

or public "in-kind" contributions, which might create a unique and useful partnership within a community, could qualify.

5. Executive-Legislative Cooperation. The governor and key cabinet leaders should meet with interested state legislators to discuss ways in which they could approach homelessness with a more comprehensive strategy. Work should also be done with the state's congressional delegation around needed changes in federal policies and programs in the areas of housing and human services.

6. State Agency Innovation. The governor should expect each state agency to develop and evaluate one or more demonstration programs for homeless people. These programs should be coordinated through the interagency group. Publicize the existence and results of these programs and of programs funded through the *McKinney Act* to enhance public awareness.

7. Long-Term Solutions. They should focus the majority of its efforts on long-term solutions, such as jobs, permanent housing, and support services for the homeless, rather than on short-term solutions, such as the creation of more shelter beds. Examine regulations in all state departments, and modify or eliminate those which constrain adequate services to homeless persons, e.g., address requirements. Look at important human services programs such as housing, employment services, and income supports to see whether their structures and operating methods militate against getting needed services to homeless persons. Finally, the state should address its role in the creation of and support of low-income housing for its most needy citizens.

Endnotes

[1] M.J. Stern, "The Emergence of the Homeless as a Public Problem," *Social Service Review* 58 (1984): 291-296.

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[3] J. Morrissey and D. Dennis, *NIMH-Funded Research Concerning Homeless Mentally Ill Persons: Implications for Policy and Practice* (Rockville, MD: National Institute of Mental Health, Alcohol, U.S. Department of Health and Human Services, 1986).

[4] Ohio Department of Mental Health, "Report to Governor Richard F. Celeste from Cabinet Cluster on Homelessness," May 28, 1985. (Unpublished)

[5] Ohio Department of Mental Health, Ohio Mental Health Housing Task Force, *Final Report* (Columbus: Ohio Mental Health Housing Task Force, January 1986).

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Discussion Paper: The Ohio Case

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All states applying to the U.S. Department of Housing and Urban Development for assistance under the *Stewart B. McKinney Homeless Assistance Act* must have in place a mechanism for the development of a Comprehensive Homeless Assistance Plan or CHAP. The state of Ohio used substantive research findings to determine who the homeless were and the reasons for their situation, and to identify the needs of those homeless and the types of problems that they were experiencing. These findings were disseminated systematically throughout the state and became the foundation for the governor's statewide coordinated effort to address the needs of homeless people. As a result, Ohio is further along than many other states in being prepared to compete successfully for *McKinney Act* funds.

Dee Roth and Pamela Hydes' comprehensive presentation of Ohio's response to homelessness raised three major, somewhat overlapping concerns that I believe should have been and need to be considered if that response is to be a "model" worth replicating in other states: (1) the top-down approach, (2) the maintenance of interorganizational relationships, and (3) the evaluation of program results.

The Top-Down Approach

The efforts in Ohio came from the top down. The governor was very involved and committed, mandating the involvement of key people within the human service and housing sectors of the state government. These key individuals formed the initial Cabinet Cluster on Homelessness. While the Cabinet Cluster may have been organized in a relatively smooth manner, we are not told any of the drawbacks of this process, whether any problems were encountered in

coordinating the initial group. Surely, some "turf" issues must have arisen. How were they handled? Suggestions for initiating this type of process in other states would have been helpful. Could other states motivate and involve key leaders such as the governor and legislators?

Maintaining Interorganizational Relationships

The dynamics of establishing and maintaining interagency, interorganizational, and public/private relationships are difficult. The activities in Ohio resulted from government initiative. What was the response of the private sector, such as church and private shelter providers, to this effort? What was the nature of the relationship of the initial Cabinet Cluster with the private sector? Was a partnership of any type developed? The initial Cabinet Cluster was expanded to create the CHAP for the state of Ohio; new members from the Department of Education, the Veterans' Administration, the Ohio Coalition on the Homeless, and other agencies and organizations were integrated into the group. How were these new members approached, how were relationships established; what were their roles in the Cabinet Cluster, and the difficulties, if any, that arose in their integration into the Cabinet Cluster; and how were these difficulties overcome?

Evaluating Program Results

How successful have the efforts in Ohio been in meeting the needs of homeless people? Specifically, what impact have these efforts had on the homeless population; for example, has there been an increase in the development of low-and moderate-income housing, and have homeless people had greater access to mental health and other social services? Has there been any evaluation of these efforts? If so, what were the findings?

The initial Cabinet Cluster proposed a number of action steps to address homelessness. How has the implementation of these action steps proceeded? For example, have proposed activities, such as the development of a strong public/private partnership, been implemented? Were there any barriers to implementing these action steps.

A cooperative approach to provide housing for the seriously mentally ill homeless—through the coordinated efforts of the Department of Mental Health, the Office of Budget and Management, the Ohio Housing Finance Agency and the Governor's Office—grew out of the initial Cabinet Cluster meetings. Has this cooperative approach been successful? What occurrences facilitated or undermined the success of this approach?

The Importance of Accurate Data

I would like to reinforce an important point in the Ohio paper: policymakers and program planners should rely on accurate data, not on assumptions or misperceptions, to define the homeless population. Data from Ohio and other recent studies show that people who are homeless are disproportionately young, male, and of an ethnic or racial minority group. This finding should not be overlooked or ignored in identifying who constitutes the homeless population. More attention must be paid to this finding in discussions of homelessness, planning for the alleviation of homelessness, and development and implementation of programs for homeless people. Among young, male, minority homeless individuals, lack of affordable housing and unemployment or underemployment seem to be the primary causes of homelessness. At least in Ohio, attempts to address these needs were made through job training activities and employment-related initiatives. Similar efforts should be pursued in other states.

Assisting the Homeless in an Era of Federal Retrenchment: The Massachusetts Experience

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In January 1983, thousands of homeless men, women, and children were wandering the streets of many cities with no place to go. At that time, very little was written or understood about their plight. In 1981, when Kim Hopper and Ellen Baxter published their study of homeless people in New York City, *Private Lives, Public Spaces*, the city was under a court order, as a result of a suit brought by the National Coalition for the Homeless, to provide shelter for all those in need. The order led to the creation of hundreds of beds in large, warehouse-type shelters throughout the city. Very few cities or states, however, had any organized response to the growing problem of homelessness at the time. Religious organizations and grass-roots groups were trying valiantly to compensate for the lack of any local, state, or federal government response.

In January 1983, Michael S. Dukakis came back into office as Governor of Massachusetts after a four-year hiatus. Greatly troubled by the growing number of homeless people in the state, he decided to focus part of his inaugural address on this problem. In so doing, he made solving the problem of homelessness his top social welfare priority. In that address, he stated:

> The children born in this New Year will graduate from high school in the year 2000. What kind of state will they inherit from us? Will they be able to afford a home—in communities that are safe and secure—will they find meaningful prospects for employment and economic advancement?
>
> There are some who would say that there is little we can do to help shape our children's future. There are others who would say that our immediate concerns are too pressing, and that we would do well

simply to make government work more effectively and more honestly on the problems of our time.

These are sensible warnings. And our present problems are indeed pressing. . . .

Thousands of homeless wander our streets without permanent shelter. *And we must provide it.*

Too many of our people—black and white, men and women—in North Adams and Athol and Fall River and South Boston—are living at the margin without hope, without a future! *And we must help them—not with handouts, but with jobs and a good education and decent housing.* . . .

First, we will reach out to those among us who are in desperate need and can barely sustain themselves.

The governor immediately convened a broad cross-section of people who could work with government to solve this pressing social problem. The governor's wife and the Catholic Bishop from central Massachusetts co-chaired the Governor's Advisory Committee on the Homeless, designed to assist in developing an action agenda to address the problem. The state's director of Human Resources was responsible for organizing the effort, and the author was brought in to coordinate and oversee the administration's response to this problem.

The Process

Eighty people were invited by the governor to be part of the advisory committee. These people represented all sectors of the community, including clergy, advocates, service providers, foundations, businesses, and various professional groups. Three subcommittees were organized to develop recommendations in the following broad policy areas: emergency services, social services, and permanent housing.

In addition to these three working groups, 24 nonprofit groups throughout the state were asked to convene forums on homelessness in order to ensure that a local perspective was included in the policy-making process. These forums were essential to the overall development of policies and programs. They helped to make clear the diversity of the problem and the types of people who were actually homeless. It quickly became evident that the problem of homelessness was different in different parts of the state.

This process also pointed to the critical need to focus not only on the emergency nature of the problem but also on the importance of prevention and permanent housing as key ingredients to any successful policy approach. Getting people off the streets would not, alone, solve the problem. It would only force the problem "indoors," leaving the causes and long-term solutions aside. We quickly decided that the "Massachusetts Approach to Homelessness" would necessarily be a comprehensive approach that tackled all facets of the problem, beginning with prevention and ending with stabilization through permanent housing and economic self-sufficiency, wherever possible. To realize that goal, however, we first needed to understand the homeless people and their needs for government assistance.

The Profile and Causes of Homelessness in Massachusetts

Very few scientific studies of the homeless were available in 1983. In Massachusetts, this information was sought through a survey of local and public nonprofit service agencies. We asked these agencies to provide a profile of the homeless, in terms of numbers and types of problems. Through this process, we developed a "Profile of the Homeless in Massachusetts." This profile, which was published in June 1983, indicated that there were 8,000 to 10,000 homeless people in the state, living either in shelters or on the streets. The survey found also that 30-40 percent of the homeless individuals suffered from major mental illness. This percentage was supported by a more rigorous research study completed by the Department of Mental Health in 1984. Further, another 30-40 percent of the individuals suffered from substance abuse problems. At that time, about 25 percent of the total homeless population consisted of families with children. The number of homeless families has continued to increase substantially over the past four years. In a 1985 study prepared for the Executive Office of Human Services, homeless families were projected to make up as high as 75 percent of the homeless population in Massachusetts.

The logical question that emerges from these alarming statistics is: What were the causes of homelessness in Massachusetts? The causes are many and, in some cases, represent the failures of some of our major social welfare initiatives over the past 20 years.

"Deinstitutionalization" is often blamed for creating the homeless problem. While it certainly is one of the factors that has contributed to homelessness among the mentally ill, it is not in and of itself the primary cause. Deinstitutionalization is an example of a social policy gone awry. It carried with it the best of intentions: to empty the overcrowded back wards of state hospitals. Unfortunately, the housing and community supports necessary to carry out this policy successfully were never put in place. In Massachusetts, for example, there were 24,000 individuals in state hospitals in the late 1960s. Yet, as of 1984, only 2,400 community beds had been put in place.

Unfortunately, the vision of John F. Kennedy in the *Community Mental Health Centers Act of 1963* was never fully realized. Thousands of mentally ill individuals were sent home to families ill-equipped to handle this burdensome illness, or were sent to ill-prepared nursing homes. Too many ended up on the streets or in shelters which were not prepared to handle the challenge these individuals presented to staff and volunteers. As Ellen Bassuk pointed out, "Anecdotal evidence suggests that in the decades before 1970 most of the homeless were unattached, middle-aged, alcoholic men—the denizens of skid row."[1] It was this population that most shelters were accustomed to seeing. Although alcohol-involved persons certainly continue to be prevalent among the homeless, the combination with those who are seriously mentally ill creates a definite change in the makeup of the homeless. The promise of federal money being provided to states to follow the clients from the hospital to the community never fully materialized.

The increased number of mentally ill in the community might have been manageable if the necessary supports had also been in place. The lack of case management and supported housing alternatives is what really created the crisis in local communities. The absence of these services, combined with inaccessibility to hospital beds, created a serious crisis in most states. In response, in 1984, Massachusetts launched a major new initiative to provide high quality in-patient care, case management, and housing for people suffering from chronic mental health disorders. The Governor's Special Message on Mental Health presented to the legislature in December 1985 proposed a sweeping program to revitalize the state's mental health system. The final package adopted by the legislature and signed into law in June 1987 includes $340 million to bring all in-patient units up to the standards of the Joint Commission on Accreditation of Hospitals and to develop 3,500 new units of permanent housing for mentally ill individuals.

The lack of affordable housing obviously has been a critical cause of homelessness, not only for mentally ill individuals but also for homeless families and children. It is in this area that the federal government has reneged on its commitment to provide housing for all its citizens. Under both Presidents Gerald Ford and Jimmy Carter, the United States was producing 250,000 new units of low-income housing each year. Under the current administration, that number has been reduced to less that 25,000 units per year.

Not only is housing not being produced by the federal government, but as Chester Hartman pointed out at the National Conference on Homelessness held at Harvard University in March 1986:

> Housing costs are steadily consuming larger proportions of household income, particularly for lower-income people. The 1983 Annual Housing Survey by the U.S. Bureau of the Census reports that from 1973 to 1983 median gross rent as a percentage of median income rose from 22 percent to 29 percent, reflecting the far faster rise in median rent (137 percent, from $133 to $315) than in median family income (79 percent, from $7,200 to $12,900). . . .These acts show clearly that renters, with far lower incomes than homeowners, have suffered far more. . . . Some two and a half million people are displaced annually from their homes. The major victims are poor, nonwhite, and elderly households. . . . The national low income housing coalition, using 1980 census data, estimates that there is a gap of 1.2 million units between the number of very low-income renter households and the number of units available at rents representing 30 percent of their incomes.[2]

Other causes of homelessness include unemployment, domestic violence, inadequate public assistance payments, and substance abuse. Any of these alone, or in combination with already cited causes, can lead to the situation of a person being without a home.

The Policy Approach

In Massachusetts, after a thorough analysis of the problem of homelessness, both in terms of who and why, a four-pronged strategy for dealing with the problem was developed. It was assumed from the beginning that the success of this approach would depend on the ability of the state to form a partnership with local government, the private sector, and the religious community. The approach included a full assessment of current state policies and programs and the extent to which they contributed to the homeless problem. It was also based on the assumption that homelessness was not a new social problem, but represented the failure of many different social policies and programs. The governor decided that rather than create a new bureaucracy to deal with this problem, he would mandate that the existing system focus on developing and implementing creative solutions to the problem of homelessness. Initially, the effort was coordinated by the governor's office and, after a year and a half, primary coordinating responsibility was given to the Executive Office of Human Services.

Prevention

It was agreed by government, advocates, providers, and consumers that preventing homeless-

ness was a worthwhile investment that would save costs in both fiscal and human terms. Once a person becomes homeless it is a most costly problem to solve. Thus, in Massachusetts, it was decided to focus as much attention as possible on preventing homelessness in the first instance.

As part of the initial review of policies and programs which needed to be changed, eliminated, or strengthened, several policies were identified which were contributing to homelessness, but, if changed, could help prevent homelessness. Many of these policies were found in the Welfare Department, and immediate regulatory and statutory changes were initiated.

Early in 1983, Governor Dukakis filed legislation to eliminate the requirement of a permanent address in order to receive general relief. This legislation, expanded by the Coalition for the Homeless, was enacted as Chapter 450; An Act to Prevent Homelessness and Destitution, signed into law in November 1983. This act expanded the state's Emergency Assistance Program by mandating a variety of benefits designed to prevent homelessness. These benefits included back payments for rent and utilities, fuel assistance, emergency shelter for up to 90 days, furniture storage, and advance rent and security deposits. It also enabled pregnant women to be eligible for all emergency assistance benefits.

In addition to removing the permanent address restriction for general relief recipients, the act also mandated case management services for the mentally ill and social services for families placed in shelters, hotels, and motels. As a result of this legislation, state spending for emergency assistance increased from $6.7 million in fiscal year 1983 to $32 million in fiscal year 1988. In 1989, it is estimated that $42 million will be spent on emergency assistance activities. This program serves over 30,000 families a year, and has been responsible for preventing homelessness for thousands of families.

Another important prevention initiative implemented in 1983 was the Family Reunification Program. This program changes AFDC regulations to allow payments to continue to a family even if the child has been temporarily removed from the home. As long as the social services plan provides for reunification within six to nine months after a child is removed, full AFDC benefits are continued. This change in regulations has allowed an AFDC parent to keep her home and not be forced to become homeless when a child is temporarily removed.

The Housing Services Program, located in the Executive Office of Communities and Development, is another prevention program that was created in 1985. This program is operated with state funds through contracts with nonprofit agencies. The program was initiated to prevent the unnecessary eviction of low-income tenants from existing housing stock. The local agencies provide housing counseling, technical assistance, and workshops for landlords and tenants, as well as direct mediation when necessary. Landlords and tenants are encouraged to work together to reconcile their differences instead of meeting as adversaries in court. In fiscal year 1987, this program served 14,383 tenants and 5,281 landlords.

Two other programs worthy of note, which were designed as prevention programs and have been operating successfully for the past couple of years, are housing abandonment and condominium conversion restrictions. The Housing Abandonment Program provides funds to bring multifamily properties threatened with abandonment back to stable ownership and tenancy. Since its implementation in 1985, this program has been responsible for preventing 1,877 units from dropping out of the housing market. The Act to Control Condominium Conversions was signed into law in 1983. This act seeks to protect low- and moderate-income households from being displaced due to condominium conversions.

A new prevention initiative was included as part of the governor's budget submission to the state legislature for FY 1989. This initiative, totaling $22.4 million, would provide for limited rent subsidies designed to prevent homelessness for families paying more that 50 percent of their income for rent. The program included a strong social services component that links rent subsidies to social services for those families who are threatened with homelessness for noneconomic reasons. For families who are likely to be homeless primarily for economic reasons, it creates an early warning case management system designed to help stabilize a family before it is forced into the crisis of homelessness. This program would be combined with the previously described housing service program to form a comprehensive program to prevent families from becoming homeless. If fully funded by the legislature, the program anticipates being able to assist over 6,000 families during the first year.

In addition to these special programs, the state also targets ongoing programs to prevent homelessness. These programs include fuel assistance, which is funded jointly with state and federal funds; food stamps, which is a federally funded program; and all income maintenance programs, including veterans assistance, SSI, general relief and AFDC. In addition the state's Employment and Training (ET) Program has been striking in its ability to provide AFDC recipients with a route out of poverty. Since the program began in 1983, over 50,000 AFDC recipients have left the welfare roles.

When despite all prevention efforts a person is still faced with homelessness, the importance of

providing emergency services becomes critical. Any successful emergency response must integrate the basic needs for shelter, food, clothing, and financial assistance. Naturally, the first step is to provide a warm, safe place for a person to sleep.

Emergency Services

In 1983, there were two state-supported shelters for homeless people in Massachusetts. Today, there are 84 shelters providing a total of 4,107 beds on any given night. The shelter model that has been developed is unique because it emphasizes small, community-based programs with 20-40 beds and includes a stable bed, meals, and day services, plus housing search and social services. While Massachusetts still supports a couple of larger, more traditional shelter programs, the smaller, 24-hour, community-based service model is preferred.

This smaller model has been particularly successful in meeting the needs of homeless families. There are 50 shelters to serve families. The average length of stay in a family shelter is 60 days, which is testimony to the effectiveness of on-site services. The Department of Public Welfare provides 75 percent of the operating costs, with the local nonprofits contributing 25 percent. This local contribution provides an incentive to involve local civic, religious, and government organizations in a partnership designed to support the shelter.

The shelters are all owned or rented by local nonprofit organizations. A key obstacle to implementing this model was an anti-aid amendment to the Massachusetts constitution which prevented the state from providing direct capital grants to the private sector. To overcome this obstacle, Kitty Dukakis approached the philanthropic community with the idea of creating a "Fund for the Homeless" to raise capital funds from private individuals and businesses. The Boston Foundation, the largest local foundation, agreed to host the fund and provide staff support. The fund successfully raised over $1 million during a three-year period and was responsible for providing the necessary start-up capital for more than 60 sheltering organizations.

In addition to the 84 state supported shelters, some hotels and motels are used for families when no other alternatives exist. As a matter of policy, the state prefers not to use hotels and motels because of the lack of adequate on-site services and support. Approximately 500 families statewide are in hotels and motels on any given night. Through the new homeless family prevention plan, the state hopes to reduce that number significantly within a year. A network of services similar to those provided in family shelters has been organized to provide support of families in hotels and motels. The Department of Social Services is responsible for assigning social workers to visit families in the hotels and offer voluntary assistance. This assistance includes counseling, access to child care, education, and other social services.

The state has also targeted shelters for people with special needs. To this end, a network of 32 shelters, with confidential locations, has been put in place for battered women. These shelters are funded by the Department of Social Services. There is also a network of 23 emergency shelters specifically for adolescents. In addition, there are transitional living programs specifically designed for pregnant and parenting teens. There are few shelters focused specifically on the special needs of mentally ill adults.

In the winter of 1988, the state was successful in working with the City of Boston and local shelter providers to ensure that every homeless person who wanted to come indoors had a place to be. The "Winter Plan" added 345 beds to the city's shelter system, making a total of 2,211 beds. Included in this plan were two new sheltering programs worthy of mention. One is an intensive psychiatric/detoxification program that focuses on individuals with a dual diagnosis of alcoholism and mental illness. The second program is a night center, which is designed as an entry point for individuals not willing to enter the more established shelter system. The night center, operated in a downtown Boston church, is a warm place for people to come, whether or not they are intoxicated. It is providing a necessary, unstructured environment for those individuals incapable of making it in a more structured shelter setting.

The state operates only one shelter directly and it is located at the state Public Health Hospital. This shelter provides 200 beds and includes a special respite care component for medically ill homeless individuals. All other shelters are operated by nonprofit community organizations under contract with the state. In most cases, the state pays for 75 percent of the shelter's operating costs. The shelter provides 25 percent through a combination of private funds and in-kind contributions.

Supportive Services

The third part of the four-part Massachusetts homeless model involves the provision of supportive services. It is based on the assumption that in order to move from homelessness to permanent housing, a person may need certain supportive services. These services include everything from basic information and referral and housing search assistance to more specialized services focused on the particular needs of the individual person or family.

Particular attention has been focused on the needs of mentally ill individuals. Experience has taught us that the people who suffer from major mental illness and are homeless need special attention. Massachusetts has launched an aggressive case

management and outreach program that includes advocating, when necessary, to get people hospitalized. It also includes support to families of persons who are mentally ill and homeless or at risk of becoming homeless. The key to this effort is the development of permanent housing units focused on the needs of mentally ill individuals. These units are being developed in neighborhoods throughout the state. Most of them are designed for four to eight individuals and include 24-hour, on-site staff support.

Other critical supportive services include medical outreach and services, day programs, transitional living programs, employment and training programs, W.I.C., and veteran's services. In each of these areas, Massachusetts has developed model programs. Transitional living programs have been designed to focus on the special needs of the mentally ill, pregnant and parenting teens, battered women, recovering alcoholics, and homeless families. The transitional living model is unique because it involves an ongoing rental subsidy attached to the unit, which is paired with operating service dollars to ensure that the unit is available for the purpose for which it was designed.

This program has been extremely successful for those individuals and families not yet ready to make the transition from being homeless to maintaining a permanent living arrangement.

Permanent Housing

Over the past five years, Governor Dukakis has signed into law three comprehensive housing acts totaling over $1 billion in bond authorization for the development of low- and moderate-income housing. These funds are being channeled through a variety of housing programs created by the state. These include:

Chapter 667—Housing for the Elderly;
Chapter 705—Housing for Families;
Chapter 689—Housing for Special Needs;
S.H.A.R.P.—State Housing Assistance for Rental Production;
Housing Abandonment Program;
Renovation and Modernization of Existing Public Housing; and
Housing Innovations Fund.

In addition to the above mechanisms which will be responsible for generating thousands of new units of housing, the Chapter 707 program (state equivalent of Section 8) has been successful in developing 13,186 units of housing in the local communities. These units have been developed by the local housing authority in partnership with a state human services agency and a local nonprofit provider.

Using individual 707 certificates, the Department of Public Welfare has placed more than 5,000 families into permanent housing from shelters and motels. This program has been costly, but very successful in getting people out of shelters and hotels and into permanent housing. When necessary, social services are provided through the Department of Social Services. This is the kind of commitment that is needed nationally so that all states can accomplish what Massachusetts has been able to accomplish because of its good economic climate.

Fiscal Costs

Until passage of the *Stewart B. McKinney Homeless Assistance Act of 1987* (*McKinney Act*) Massachusetts had to rely almost entirely on state dollars to support this extensive network of services for homeless individuals and families. The state has increased its fiscal commitments from over $12 million in FY 1983 to over $200 million requested by the governor for FY 1989.

Almost all of the programs listed are 100 percent state funded, with the exception of the Emergency Assistance program, which is 50 percent federally reimbursable. New federal regulations, however, have been issued to cut reimbursement for this program from 90 days to 30 days. This will require the state to pick up the difference in the cost because most homeless families in Massachusetts stay in shelters for an average of 60 days and in hotels for an average of 90 days.

The *McKinney Act*, while providing new money, will not defray the ongoing costs the state has incurred in the absence of any such federal program. The *McKinney Act* requires that these funds be allocated to new programs or to expansions of existing programs. Thus, while these funds will be sought and used in Massachusetts, they will not change the state's existing fiscal burden.

Massachusetts has been able to absorb these costs with state tax dollars because of the excellent economic base of the state. The state has been able to enhance revenues by closing tax loopholes and aggressively pursuing tax evaders. Millions of dollars of previously lost revenue have been returned to the state to be used to support important human services priorities. The homeless programs have been one beneficiary of these revenues.

Coordinating Structure

A key element in implementing the Massachusetts model has been the coordinating structure that has been put in place. The Governor's Advisory Committee on Homelessness provides an overall mechanism for involving providers, advocates, and state officials in the policymaking process. A planning committee, which meets monthly, ensures regional input and more intensive review of proposed policy changes.

The Executive Office of Human Services (EOHS) has been given the principal responsibility for coordinating the activities of state government.

To this end, EOHS chairs an interagency committee that is comprised of all state agencies involved with the problem of homelessness. This group includes not only agencies from within the human services secretariat (Welfare, Social Services, Mental Health, Public Health, Veteran's Affairs, Office for Children, Rehabilitation Commission) but also agencies from other secretariats (Communities and Development, Elder Affairs, Administration and Finance). More recently, the Department of Education has been added to this group.

Rather than create a new or separate bureaucracy to deal with the problem of homelessness, the Massachusetts approach has been to have all agencies of government focus on how they can better address the problem using the four-part policy approach. In this way, not one but all agencies are focused on prevention, emergency services, supportive services, and permanent housing.

The cooperation of cities and towns, community action agencies, other community-based organizations, and civic and religious groups has been the key to the successful implementation of these programs. Local coalitions and interagency groups provide an ongoing mechanism for informing the state about the success of these programs, which are being designed and implemented by local groups and governments.

Conclusion

Homelessness is a costly social problem. Any efforts to solve this problem must focus simultaneously on short-and long-term solutions. Prevention of homelessness must be a key ingredient in any successful strategy. Similarly, there must be a focus on long-term solutions, including permanent housing and employment. Massachusetts has developed an approach that is beginning to show enormous benefits. Over the past 18 months, 6,000 families have been placed in permanent housing. Thousands of individuals and families have been prevented from becoming homeless due to a combination of housing services and income supports. The state is back on its way to developing a first-class mental health system that focuses on both high quality in-patient care and a comprehensive network of community services.

The challenge for government is to target limited resources where they can have the greatest impact. Choices inevitably need to be made, but, if the right people participate in making these choices, the likelihood of success is greatly increased. In order for state and local efforts to succeed, there will have to be an increased federal commitment to ensuring that all citizens have equal access to decent, affordable housing. Housing must be seen as a basic right if we are to win in our struggle to end homelessness. We will succeed only if and when federal, state, and local governments, in cooperation with the private sector, join together in developing realistic solutions to a most complex problem.

Endnotes

[1] Ellen Bassuk, "The Homelessness Problem," *Scientific American* 251 (July 1984): 42.

[2] Chester Hartman, "The Housing Part of the Homelessness Problem," in *Homelessness: Critical Issues for Policy and Practice* (Boston: The Boston Foundation, 1987), pp. 13-15.

State Coordination of Mental Health Services to Homeless People in Massachusetts

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This paper examines interagency and intergovernmental cooperation in dealing with mental health and homelessness. It will cover the following areas:

Why mental health professionals are involved in coordinating interagency policies and services to deliver services to homeless people.

The role of mental health in the process of "communitization."

The Massachusetts model of delivery of mental health services to shelters.

The importance of applying mental health principles in planning programs and services for homeless families.

Significant obstacles to the development of an interagency and intergovernmental approach to homelessness.

Specific policy recommendations for state and local mental health administrators.

Mental Health Professionals and Interagency Coordination

Why should the mental health professionals be concerned with interagency coordination of policy and services to homeless people? Why don't they stick to their pills, mental hospitals, and psychotherapy, and leave the interagency issues to the "policy people"?

The answer is that mental health issues are an integral part of the experience of homelessness. To address the mental health issues of homeless people effectively, the whole experience of homelessness must be addressed.

A system that would deal only with the mental "health" or "illness" aspects of homelessness would be impossible to run effectively. It cannot and should not be done. Research has shown that a clinician must work in tandem with other actors in a patient's

life, within the interpersonal system of the patient's daily life, and must meet the patient at his or her level of functioning in order to begin a therapeutic alliance.

In the case of the housed or settled patient, the clinician is continuously engaged with the patient and his or her environment. These patients are in an environment where basic life needs are met (food, clothing, shelter, and "belonging"); in addition the patient usually has made a decision to seek psychiatric help. In the case of extreme psychosis, involving involuntary hospitalization, the patient does not make this decision. Thus, the mentally ill housed person comes from a life of at least some predictable givens. This modicum of stability is not available to the homeless person. The homeless must simultaneously seek satisfaction of material and psychological needs of the most profound nature. A homeless person is in a chronic crisis of instability. Both the mentally ill homeless person and the homeless person without a major mental illness need relief from the crisis of a daily life struggle for survival before either can be helped emotionally.

The first factor in a psychotic patient's life that is addressed by a clinician is the patient's stability. An in-patient unit provides a therapeutic stabilization through personal relationships and medications. In the case of the homeless person, the first need that has to be fulfilled is daily survival, even if it is in shelters and/or on the streets.

Thus, the mental health specialist should make the creation of an effective shelter system the first concern. This can be accomplished only by interagency coordination in planning and programming. Both the "mental health" and "mental illness" aspects of homelessness can be dealt with only in concert with governmental agencies addressing issues of poverty. Every state has agencies that deal with welfare family services, public health, housing, specialized services for the elderly, veterans, school age children, and disabled people. The mental health professionals need to align themselves with individuals from the aforementioned agencies in order to develop effective policies.

The *Mental Health Center Act* (1963) and the subsequent massive deinstitutionalization turned the attention of professionals away from their customary interaction with psychotic patients in state mental hospitals, private psychiatric institutions, or in the privacy of a doctor's office. In the 1960s and 1970s, these professionals began to expand the dimensions of their concern to the community and its structures. Gerald Caplan, in his work *An Approach to Community Psychiatry* (1961),[1] outlined the new role of clinician turned administrator. This work, often deemed "the Bible" of the mental health center movement, is filled with chapters on how to make interorganizational connections between the center and places in the community where mentally ill people are likely to live, such as nursing homes and prisons. He describes interorganizational techniques to build bridges between those who control these community environments and the mental health practioners in the community.

Today, the role of the mental health professionals has expanded well beyond those spelled out by Gerald Caplan. A complex of local, state, and federal interagency relationships has sprung up. It has to be intergovernmental in order to affect the policies and planning of agencies that deal with the creation of a community network of supports that would be likely to lead to a successful placement in to permanent housing and a new social "home-base." The mental health professional has the knowledge to help inform the policymakers and planners about how to accomplish this objective successfully.

An effective program that reduces homelessness is one that strengthens community. The mental health agency should be an integral part of such community building at both state and local levels.

Mental Health and Community Building

Looking at the homeless person's options from a mental health point of view advises the clinician as to whether all the parts of a community support system are in place. Looking at the experience of homelessness this way, from the individual's psychological point of view, shows that being stripped of one's clothes on admission to a hospital and losing all signs of identification of oneself (clothes, bureau, pictures, own bed, etc.) was dehumanizing and contributed to the patient's overwhelming inability to deal with the experience, much less his or her psychosis.[2]

The same is true for the person who has to cope with not only mental illness but also the stresses of the homeless experience. Even for those not affected by mental illness, the homeless experience can be a disastrous psychological experience, preventing the person from restabilizing even when other social services are provided.

A systematic planning process can assess the options that exist for homeless people in the community, and help to develop the necessary support systems to get people out of homelessness. Or the community can simply allow options to sprout up either from people's uncoordinated goodwill or from a haphazard set of options for using whatever monies happen to be available, regardless of whether they meet the real needs in the community. This is how a city can end up with 24 soup kitchens (but none operating on Sundays), three uncoordinated emergency nighttime shelters, and no day shelter program. The same money could have been spent to offer a coordinated set of shelters, a community settlement

house with meals, and state human service agency staff at the day program, including mental health specialists.

It is especially important that fiscal resources be targeted toward the goals of a planned web of options designed to help people out of homelessness. For example, a massive emergency shelter response is not only extremely costly but is also self-defeating. Furthermore, if a mental health agency in a community acts independently and simply expects shelters to send people to them for "treatment," it will spend its resources without ever seeing most of the mental ill homeless.

There are eight interrelated factors whose operations are likely to generate stability and positive personhood in the "homeless system": a responsible agent, predictable shelter, adequate and stable shelter, positive daytime options, entitlement to benefits and services, access to benefits and services, health services, and adequate housing.

When any of the eight factors is missing or too weak, the network becomes unbalanced and can negate the system's ability to be supportive. Therefore, it is important that attention be given to the whole system, and not simply one aspect of it. The eight factors are discussed below.

A Responsible "Agent"

There should be an inclusive planning group, with an acknowledged leader who is recognized by others at the city and state level as the voice for the group. A major problem for mental health professionals and other interested parties has been the struggle to figure out who is responsible for planning and coordinating various homeless programs. When there are more than two lead agencies, parallel programs develop that not only confuse and dilute state and foundation funders, but also confuse things for homeless persons who need a set of integrated, coordinated, comprehensively planned options and services. There needs to be one group that meets regularly, and the mental health agency at the local level should be an active member of that group.

Predictable Shelter

An effective information and referral system is essential for homeless people. It is completely destabilizing to people not to know where to get shelter. In a small town this may mean having the local soup kitchen and the police communicate with each other. In a major city, this could entail an office of emergency shelter at the city hall, with a computerized information network that could easily locate vacant shelter beds.

Adequate and Stable Shelter

This factor focuses on two critical aspects of sheltering: adequacy and stability. Shelter that requires people to line up and take a new bed every night is not stabilizing. This situation constantly forces homeless persons to focus on new people and deal with new situations, an extremely difficult task for someone who is psychotic, as well as to those who are not mentally ill but simply have no "home base."

Until Erving Goffman's 1961 study, it was common practice on the back wards of state mental hospitals to keep patients in a constant state of destabilization by not assigning them a specific bed, not allowing them to keep their own clothes, not encouraging personhood in any way. This same practice is continued today in many big city shelters. This constant destabilization force increases the chances that a person's homelessness will remain chronic and reduces the likelihood that a mental health worker can establish a relationship with a homeless man or woman.

Positive Daytime Options

Like most adults and children, homeless people need a positive and structured daytime life. People need a social role and an opportunity to "see their way out of" homelessness. Without this role, life loses its meaning. It is rather pointless for a community to design a night shelter system and not address the daytime lives of homeless people.

In smaller cities where there is only one shelter, it makes sense for single adult shelters (ranging in size from 20-40 people) to set up their own day program that can serve as both a social center and an advocacy center. In cities where there are more shelter beds, it is more appropriate to set up a free-standing day shelter center. This can function in the way that the "settlement house" did in the 1800s. It can serve as a place where isolated people are welcome to come for friendship and hospitality, and where a myriad of resources are made available as well, including access to mental health specialists.

Such a program exists in Boston for single adult homeless people; it is called the St. Francis House. A generic model of such a program is described by Gary A. Morse in his 1986 report *A Contemporary Assessment of Urban Homelessness: Implications for Social Change*.[3] Such "resource centers" can address some of the very fundamental needs of homeless people. Aside from the basics of housing and temporary shelter, the constellation of problems and needs of the homeless are:

1. Inadequate food and nutrition;
2. Shortage of clothing;
3. Sexual victimization;
4. Criminal problems (including legal/police harassment);
5. Poverty and financial assistance;
6. Poor physical health and inadequate medical service;

7. Drinking problems and alcoholism;
8. Mental health problems and disorders;
9. Negative or low self-esteem;
10. Low self-confidence;
11. Social isolation and the absence of a supportive social network;
12. An absence of day activities and programs;
13. An absence of leisure and recreational activities;
14. Poor work skills and job training needs; and
15. Employment needs.[4]

The most important mental health planning principle here is to know that these needs continue even after an individual obtains housing. The advantage of such a free-standing social resource center is that people who make it into permanent housing after using a shelter do not have to give up social ties in order to gain a permanent roof over their heads.

For the same reasons, it is imperative that the public departments of mental health develop social clubs, built on the Fountain House model. Such a place could serve the same function for those who are chronically psychotic. It must be noted, however, that it is critical to have a generic day or social resource center for all homeless single adults so that those who truly are mentally ill can participate in a nonthreatening way. They would not be prevented from participating because of their mental illness; nor should they have to identify themselves as mentally ill in order to get in. From that setting, with the help of the resident staff, the mentally ill can make the transition to a day program if that is deemed appropriate and is desired by the mentally ill person. Centers like this are essential to any system of care designed to treat today's increasing numbers of socially and economically marginal people.

For families, this aspect of day structure is particularly important. Parents should be engaged in meaningful activities to gain housing, social benefits, and the benefits of peer group parenting support. Again, in small cities, it could be the shelter that sets up "after shelter" groups for parents. However, free-standing family life support centers can potentially provide longer continuity of support, and families do not have to become homeless to gain admission. Indeed, virtually every community could benefit from such a program.

A successful family life support center has existed for more than ten years in Brockton, Massachusetts,[5] sponsored by Catholic Charities with support funding by the Massachusetts Department of Social Services. Initially serving only alienated parents, from the housed community, it now also takes referrals from the local shelter. It has become a centerpiece of the homeless community support network.

Again, the "undoing" of homelessness requires strong steps to create the conditions for "community," not only "housing." What used to happen in apartment buildings in the inner cities and across backyard fences of suburbia no longer happens. Mobility and urban upheaval have changed all of that. For some, the home is dying and the neighborhood is dead.

Entitlement to Benefits and Services

Homeless people in many states have been denied basic entitlement benefits because they do not have a fixed address. These inflexible rules need correction, not only at the local and state levels, but at the federal level as well. Supplemental Security Income (SSI), the federal program created to provide income for mentally ill people and others who are unable to work, should be available to all homeless people who qualify.

At the state level, it is important that SSI-eligible patients begin receiving benefits before leaving in-patient status, that patients be allowed to keep their benefits if they return to in-patient status, and that their benefits not be reduced when they reside in shelters. Without these continuing benefits, the patients are destabilized, but it takes interagency cooperation between the mental health professionals and others to avoid that fate.

Access to Benefits and Services

Benefits and services mean not only such entitlements as SSI but also legal, educational, and mental health services. All the helping services of the state should be available to the homeless person to assist in the stabilization process.

In contrast to entitlement, access means such things as: "Is there outreach to those entitled to benefits?" "Is it easy for the person to get the benefits once aware of them?" Sometimes this means "handholding" a person through a bureaucratic system. Sometimes it means that the "sign up" office needs to move to the site of the shelter. It is not enough to legislate such benefits as a right. Again, this means interagency coordination among all governments.

Health Services

Health services rightfully belong to the above mentioned "entitlements"; however, their importance is so central to the life experience of the homeless persons that health has been singled out as a separate category.

Everything about the experience of homelessness is counter to what is good for "health." Sometimes this is not obvious to the lay public or to the mental health professional. It is important, however, that both realize that mental health delivery is secondary to basic health practice. Indeed,

many mental illness syndromes are a result of deficiencies in physical health. If an individual is mentally ill, that is often a factor interfering with basic health care, distorting ability to decide such things as what foods to eat, where to sleep, and with whom one can interact (such as avoidance of medical people or hospitals).

It is only at the interagency level that one can address the underlying basic life situation for a homeless person on which later mental health interventions depend. Also, it is at the interagency level that one needs to plan local on-site "health care for the homeless teams" of health, mental health, and substance abuse specialists.

The basic mental health system in a given state should include a full set of services for the acute and/or chronic mentally ill person. This includes mobile emergency services, clinical services, case management, housing, and community education, as well as adequate in-patient services for the acutely disturbed and social support rehabilitation services for the chronically mentally ill. It is not useful for a state to have comprehensive mental health services and a lack of on-site mental health services at shelters—or the reverse. To accomplish competency of services in both places requires careful interagency policymaking.

Clearly, substance abuse has increased in every class of American society. All states have need of a full array of services for addiction problems. As with mental health, however, it is important that outreach by experts in the substance abuse field be available at shelters and on city streets. Specialized substance abuse shelters should be created, with specialized staffing from the mental health system.

In Massachusetts, 28 percent of the more than 2,200 shelter beds across the state are reported to be filled by substance abusers, and another 20 percent by both substance abusers and severely mentally disturbed people. Such specialized shelters could become the first step toward treatment and recovery, and toward supportive housing for the chronic user.

Adequate Housing

Two types of housing are needed for homeless populations: (1) affordable, safe, nontransient housing, and (2) specialized supportive housing. Failure to develop both options adequately means a backup of populations in the network of supports, rendering them unworkable. Intimacy and trust cannot be developed effectively in an overcrowded megashelter system. Further, a city generally should not have more than one emergency shelter. Other specialized transitional shelters may exist, but two emergency shelters keep a population "on the move" and inaccessible to mental health specialists and many other helping systems.

One highly successful form of housing for the mentally ill homeless, developed in Massachusetts, is the Congregate Supportive Lodging House. Nine such programs were initiated in 1986. Each required a 60 percent admission rate of homeless mentally ill people from shelters, and 40 percent from state in-patient units. In addition, it has been recommended that these lodging houses with on-site support be able to accept those with substance abuse problems. Many of the most severely mentally ill homeless people have been screened out because of their abuse of alcohol or drugs. The goal of such programs is the development of generic supportive housing for multiproblem homeless people (with minimal amounts of regimentation in living) and full connection to the basic mental health system.

Mental Health Shelter Services in Massachusetts

In 1983, the state administration initiated an interagency team of key human services and housing managers in government. Prior to this, the mental health agency had tried in isolation to address the needs of the mentally ill homeless (e.g., creating a mental health shelter in Boston in 1980 and forbidding in-patient discharge to shelters). However, lack of interagency policy and service coordination paralyzed the development of a fully responsive Department of Mental Health (DMH) system for homeless mentally ill people.

Part of the 1983 statewide initiative was the signing of the nation's first broad anti-homelessness legislation which addressed a multiplicity of factors causing homelessness. Key for the DMH was the part of the legislation (Chapter 450, 1983) that mandated that the Department of Mental Health provide case management for its chronically mentally ill clients, including the homeless. This case management was designed to be properly supported by a good clinical delivery system that could help to prevent more mentally ill people from becoming homeless. The support system established includes food, clothing, shelter, health care, and cash assistance benefits, plus provisions for the local interagency relationships essential to making the system work for homeless mentally ill persons.

In 1985, DMH created a senior management position of director of Homeless Services. Each local service area was asked to identify a senior manager whose responsibility would be the development of homeless services.

The largest service area in the state (metropolitan Boston), which was made up of six separate local service areas, was asked to merge into a regional operation for the development of homeless services. The following year, the six areas were merged administratively into one. Boston continued to develop more supportive 24-hour mental health shelters based on the model developed in 1980. A separate Homeless Services Unit was created for the city, and, within it, an elaborate set of shelter mental health services began to develop. The services included a street/shelter outreach team, 6 to 10

special mental health center beds for diagnosis and evaluation of mentally ill homeless people, a dual diagnosis detox unit for psychotic substance abusers, a psychiatrist on a specially funded "Boston Health Care for the Homeless Team," seven full-time on-site senior psychiatric nurses working at four of Boston's largest shelters (more than 1,200 beds), and specialized mental health housing for "graduates" of the mental health shelters.

After a DMH field survey of 70 shelters outside Boston, a 1988 DMH *Shelter Services Policy* mandating the availability of a standardized set of mental health services will be offered to each shelter for all homeless individuals and families. The basic set of mental health on-site services to be offered are: (1) psychiatric consultation by a master's level clinician; (2) on-site emergency services; (3) on-site case management; and (4) on-site mental health education and training. The availability of services is to be affirmed in a cosigned Letter of Agreement between the DMH and each shelter director.

It is critical to understand that none of the above initiatives would have been possible without interagency policymaking and coordination of services all the way up to the commissioner's level in state government.

Mental Health Services and Homeless Families

The largest category of homeless people today is children. The problems of their emotional development and maldevelopment are beginning to be documented. While the same principles of policy and programmatic development are applicable for this population, the consequences for failure to develop an interagency approach to support homeless infants and children are potentially catastrophic. Indeed, the consequences of homelessness for children are greater than for adults.

Infants and children need stability in their lives in order to become and stay mentally healthy. Switching schools, the trauma of losing important childhood relationships and/or dealing with a parent under extreme negative emotional stress leave emotional scars on a child for life.

Policy Recommendations

Those who accept the challenge of developing mental health services for homeless people, or any services for homeless people, must realize that the very nature of the work is an "up-hill" battle. Both the mental health systems and the larger human services community are resistant to change. Stimulating commitment to changing societal values is the biggest obstacle to institutional change. That obstacle means that public education by mental health professionals, at every level of government, must continue to be an important tool in the building of support for community systems that work.

The following recommendations can help to facilitate the development of policy and programs that will meet the mental health needs of homeless people:

1. Create an infrastructure within state agencies of human services and housing to deal with homelessness. Simply put, assign someone with management seniority the job of beginning to address the issue. Make sure that the mental health agency is on the list.

2. Create an ongoing interagency planning team made up of those management people.

3. Conduct a statewide field study asking each community, through a nonprofit lead agency, to assess not only the numbers and profiles of homeless people in their area but also their homeless community support systems, according to the analytical framework described in this paper. Give competent technical assistance to field workers so that assessments are systematic and an ongoing working relationship is begun between community and state administrations.

4. Issue a public report—setting goals and objectives for each agency.

5. Require the state department of mental health to: (a) develop the objective of building its own infrastructure on homelessness within its entire agency; (b) do a public field study on mental health services to the homeless; (c) make a public report on its findings; and (d) set its own goals and objectives within the context of interagency plans.

6. At the interagency level, with open input from advocacy groups and local governments, pick three objectives that can be accomplished and proceed to carry them out. Make sure that each agency, local government, and advocacy group has some role to play in these three objectives.

These initiatives will start a process of public commitment to the work at hand. The intergovernmental and public-private process of building a community support system is essential to the outcome. The short-term goal is to aid the homeless; the long-term goal is to set the conditions for enhancing community life.

Endnotes

[1] Gerald Caplan, *An Approach to Community Psychiatry* (New York: Grune and Straaton, 1961).

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[3] Gary A. Morse, *A Contemporary Assessment of Urban Homelessness: Implications for Social Change* (St. Louis: University of Missouri, 1986).

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Milwaukee's Outreach to the Homeless Mentally Ill

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Outreach has been recommended during the past several years as a means to help meet the needs of persons described as both homeless and mentally ill. The American Psychiatric Association (APA) suggested, for example, that the reluctance which many homeless persons express about having contact with mental health personnel could be overcome by aggressive outreach. The task force responsible for the APA report recommended that psychiatric services be provided assertively, meaning that mental health personnel should go to the "patients" if the "patients" will not come to them. The departure from office-based practice explicit in this recommendation would seem to hold great promise for meeting the needs of homeless persons in a better way. Unfortunately, however, there are few guidelines for communities interested in turning the recommendation into a functioning program.

Reaching difficult-to-serve homeless persons was the topic of a conference on mobile outreach programs held in February 1987. The conference, which was sponsored jointly by the Clearinghouse on Homelessness among Mentally Ill People and the Intergovernmental Health Policy Project of George Washington University, made it clear that while there is growing interest in the development of outreach programs, conflicting views on the purpose and nature of such programs are emerging. Some of the questions debated at the conference included: (1) should outreach teams offer food and clothes to people they engage, or does this form of help only encourage people to stay on the streets; (2) should outreach teams be empowered to transport individuals involuntarily to psychiatric facilities; (3) should mobile outreach teams be organized as another form of case management?

The reasons for the flourishing interest in outreach and, more generally, serving homeless and mentally ill persons are obvious to anyone who visits urban centers across the United States. Unkempt and sometimes hallucinating persons in tattered clothes are visibly present in many cities. Studies on this population funded by the National Institute of Mental Health estimate that between 25 percent and 56 percent of homeless persons are mentally ill. The wide variation of these estimates is attributable primarily to differences in research methodologies, but also to true differences among the populations examined. Alcohol abuse is also widely prevalent among homeless persons as is the co-occurrence of alcohol abuse, drug abuse, and mental illness.

This paper describes the design, operation, and results of a program in Milwaukee, Wisconsin, that is targeted to homeless persons who, for the most part, refuse to use existing treatment services, whether for mental illness, alcohol abuse, or drug dependence, despite readily visible evidence that they could benefit from such care. The characteristics of Milwaukee's homeless population, although smaller in total size than that of Chicago's, proportionately parallel the characteristics of homeless persons in Chicago as described by Peter Rossi and colleagues. Among the estimated 750 single adult homeless persons in Milwaukee living in temporary shelters or on the streets at any given time, the rate of alcohol abuse, mental illness, and their co-occurrence has been placed at 72 percent. In order to help those individuals who refuse to use services, or have difficulty using services appropriately, the outreach program was started through the efforts of Milwaukee's Coalition for Community Health Care, a consortium of county, city, and private agency representatives. Because it brought together important health and social service organizations and the public and private sectors, and because of its experience in administering the Health Care for the Homeless Program funded by the Robert Wood Johnson Foundation, the coalition was seen as the ideal setting for the outreach program. Milwaukee's experience with outreach has implications not only for program practices but also for policies related to long-term mental health care and the broader spectrum of basic social welfare services.

Distinguishing Characteristics of Outreach

The current vogue enjoyed by outreach programs has an implicit danger. As the concept gains favor, many diverse approaches and activities are being subsumed under the label of outreach. Consequently, the concept is quickly losing its meaning. The danger is that policymakers, advocacy groups, and interested citizens could be misled by those who claim to be doing outreach when, in fact, they are not. The situation is now reminiscent of a question reportedly raised in a speech once given by Abraham Lincoln. During the course of the speech, he posed the following question to the audience: "If the tail is included, how many legs does a cow have?" Of course a member of the audience immediately answered five legs, to which the President responded, "No, calling a tail a leg doesn't make it one." To paraphrase, labeling any type of mobile team working with homeless persons as outreach does not make it outreach.

A litmus test for outreach programs is their value orientation. The approach of the Milwaukee outreach program is modeled after the results of a research project funded by the National Institute of Mental Health and conducted in Milwaukee in 1985. The project's methodology dictated that efforts be made to conduct lengthy, in-depth interviews with homeless persons. During the course of interviewing on the streets, it was realized that more success in reaching client-resistive homeless persons could be achieved by listening to them rather than doing for them. One experience that exemplifies this orientation occurred when a project interviewer, who routinely spent her time on the streets, made contact with a reclusive woman whom other interviewers had been noticing for several weeks. The woman had quickly repulsed the other interviewers who had tried to talk with her. To make contact, the interviewer's initial tactic was simply to sit quietly nearby wherever she happened to find the woman resting. After doing this on several occasions, the homeless woman finally motioned to the interviewer, indicating that it was all right for the interviewer to approach her. They talked at length a number of times afterwards, sharing stories about who they were and what they were doing. Although the interviewer found the woman's stories to be disjointed at best, she persisted in making contact. During one conversation, the homeless woman mentioned that she had a friend she would like the interviewer to meet. A time and a place for the meeting was arranged. When the interviewer arrived at the agreed on place several days later, she waited and waited, but neither the homeless woman nor her friend appeared. Days later the interviewer happened to notice the woman on the street, and, with her exasperation evident, asked, "Where were you, I waited several hours." The homeless woman nodded knowingly and replied that she and her friend had watched her from a distance the entire time. She went on to explain that they only wanted to see if she, the interviewer, could really be trusted. Meeting someone they could trust from the "non-homeless" world apparently made a significant impression on these two homeless women. They continued to see the interviewer and began to discuss

with her options for leaving the streets. Eventually, they did seek conventional shelter.

The experience of this interviewer illustrates that outreach is first and foremost a process of relationship building. Second, it is important that power between homeless individuals and outreach workers be shared. The interviewer was a member of a research project that did not provide resources or services. The intent of the project was merely to describe the extent and nature of homelessness. The interviewer's role did not include arranging shelter or otherwise convincing homeless persons to leave the streets. By meeting as equals, both parties learned to share and, eventually, trust. The homeless women were never told what they should do, but instead, what they could do. Ultimately, the power to decide to make things better rests with the homeless person, a concept that is easy to forget when working with severely disabled persons.

Building relationships and sharing power, concepts that are embedded in much of the work that mental health professionals do with middle and upper class clients, have been linked to a number of efforts directed at homeless persons. Ellen Baxter and Kim Hopper have shown how homeless persons could be reached by respecting their well developed sense of suspicion that is nurtured by living on the streets. Similarly, Marsha Martin describes how the apparently dysfunctional behaviors of homeless women reflect coping strategies that imply ingenuity and strength that can be channeled into positive changes. Ann Slavinsky and Ann Cousins also concluded that bizarre behavior may represent adaptive or coping strategies that can be understood and redirected through mental health intervention. With these insights, the Milwaukee outreach program was started in late 1986 by the Coalition for Community Health Care through a grant from the Milwaukee Foundation.

Less Is More

The outreach program started with a single two-member team, both men, working out of a van five days a week from late morning to early evening. Perhaps more important than the food (primarily coffee and soup) and clothing they carried with them were their life experiences. Both have what might be called "checkered" backgrounds involving brushes with the law, unemployment, alcohol and other drug abuse, and homelessness. The decision to employ these individuals was based on the premise that the effectiveness of the program would rest not only on its message and context but also on the social distance between the communicators and the receivers.

In contrast to those who contend that the full array of mental health services including involuntary psychiatric hospitalization should be brought to homeless mentally ill persons at the very outset, the outreach model rests on the assumption that at the outset of intervention, less application of intensive and costly mental health treatment approaches is more effective. Seemingly an oxymoron, the concept of "less is more" is embodied in four principles that guide intervention. The program embodies less professional distancing, less rigidity, less intrusiveness, and less directiveness.

Less Professional Distancing

The outreach workers make initial contact and continue to see homeless individuals where they live, sleep, and eat. This approach follows directly from the APA's recommendation that if homeless persons refuse to come the offices of mental health personnel the workers need to leave their offices and go to them. The outreach workers do not see any of their clients, even those who are now housed and living a more normal life, in their offices. All of their work is conducted in the field. A lessening of professional distancing is also accomplished by the choice of staff members. After four years of college, several years of graduate school, and post-graduate internships and advanced training, it is not easy for mental health professionals, most of whom now prefer the label of psychotherapist, to stand among the shabby, drunken, and hallucinating homeless for any length of time. Their training and orientation virtually prevent them from conducting this type of field intervention.

Less Rigidity

The workers respond to the expressed needs of homeless persons as best they can, even if the requested resource is not directly available from the program. There are two important aspects of this principle.

First, the outreach workers respond to needs as they are identified by homeless persons. The worker's primary role is to present options and potential consequences, not solutions. This point is easy to overlook, especially by those who are well aware of their options in life. However, many homeless persons are simply unaware of alternatives. Instead, the message they have received, directly and indirectly, is that they are consigned forever to the fate they are now experiencing—that they deserve to be homeless. Some homeless people do not know, for example, that they may be eligible for Supplemental Security Income. Others who have dropped out of treatment programs in the past are unaware that there are programs willing to give them another chance. In any event, an effort is made to try to help homeless people get what they decide they want, not what the workers think they need.

The second aspect of the principle of less rigidity concerns the limitations of the outreach program.

Essentially, the program offers companionship and support. Besides coffee, soup, and a few articles of clothing, the workers have no resources directly within their purview. They rely on their relationships with other providers for most services. When a homeless person decides that it is time to see a medical practitioner about an ailment, the workers can contact a medical clinic sponsored by the Health Care for the Homeless program to arrange an appointment. Both the workers and homeless persons traverse the service system as it is.

Less Intrusiveness

On a bitterly cold night this past winter, a charitable group decided to take their large, well-equipped mobile canteen throughout Milwaukee's inner city looking for homeless persons to help. Crews from several local television stations accompanied the canteen. After a time, the workers in the canteen spotted a man resting against a building in an alley. As the vehicle approached the man, one of the good samaritans got out with a cup of soup in hand. However, before the offering could be made, the man in the alley got up and ran away. Finally, after following the man for several blocks, the canteen worker cornered him at a bus station. The kind, gentle canteen worker walked over to him and asked, "Why did you run, I only wanted to see if we could help you?" The man replied in effect, "Wouldn't you run if somebody drove that thing into your house?"

This textbook case of how "outreach" can easily go awry illustrates that homeless persons, particularly those who have been on the streets for lengthy periods, perceive themselves as having a home. It may be a primitive impulse, but staking out one's own space is a common, primal instinct. Especially among long-term homeless persons, concepts of "my space" appear to be very strong. This is understandable in light of the fundamental fact that maintaining even a minimal measure of dignity is extremely difficult for those who live their lives in public spaces.

Clare Concord argues that by defining space a homeless person can become both physically and emotionally invisible in an otherwise public setting. The paradox is that while invisibility increases the chances of physical survival in a hostile urban arena, it threatens emotional survival as isolation from the outside world deepens. Concord writes that "what is needed to survive physically threatens emotional survival." A profound sense of distrust is a necessary coping mechanism for street life, even if it presents difficulties for well-meaning canteen workers trying to deliver hot soup in the middle of the night.

Recognizing the significance of space, outreach workers first try to be acknowledged by homeless persons who appear fearful or reclusive. It may take several encounters before the workers receive a nod or other sign. Then they wait to be invited closer. This initial period appears to be critical. If the workers intrude unknowingly, their chances of building trust with the person diminish quickly.

Less Directiveness

The outreach worker's first role is to listen. While seemingly a simple task, the power of merely listening has almost always been overlooked in the design of programs for homeless persons. Inevitably, the typical program design begins with a worker making an assessment, prescribing a course of action, and in some instances, monitoring compliance. The language of this approach reveals why it frequently fails when applied to individuals who resist the client role. The picture conveyed by the language is one of an authoritative agent doing most of the work: assessing, prescribing, monitoring. Moreover, the whole plan is typically based on a relatively brief encounter with the individual in question.

If there is one common characteristic among homeless persons, whether mentally ill, alcohol abusers, or mothers with children on welfare, it is social isolation. They appear to have minimal personal support systems. Peter Rossi and colleagues conclude that, as a result, homeless persons are "especially vulnerable to the vagaries of fortune occasioned by changes in employment, income, or physical, or mental health." Once homeless, a person tends to perpetuate isolation from the non-homeless world. Although most such persons seem to have some affiliations with other homeless persons, keeping away from the non-homeless is a common behavior that seems to increase the likelihood of one's survival on the streets. Isolation breeds mistrust, and persons who are unable or unwilling to trust have minimal support systems. Without support from others, the isolation deepens.

To overcome the profound sense of mistrust exhibited by homeless persons toward the outside world, the outreach worker learns to wait and listen. The behavioral messages sent by the outreach worker acknowledge that: (1) they are now on the homeless person's "home turf"; (2) the power to initiate the relationship rests with the homeless person; (3) there is an alternative, in the presence of the outreach worker, to isolation.

Once homeless individuals feel comfortable and begin talking, our experience shows that most have a great deal to say. Although a few choose to say very little, many seem to enjoy a sense of relief in sharing their life experiences with the outreach team. During these encounters, the message of the outreach worker is that you, the homeless individual, are important and so are your experiences in life. The therapeutic effects of these unspoken messages are apparent as manifestations of anxiety and mistrust diminish in frequency and intensity. The content of

these life stories is frequently difficult to follow, especially as told by persons who appear to be mentally ill or alcohol abusers. The content oftentimes changes with each successive encounter. However, at this stage of the relationship, the content seems much less important than the telling and the listening.

Outreach workers consistently are faced with the question of how to pace their relationships with homeless individuals. How often should they seek out a specific individual? When should they start presenting options? These are difficult questions, and the urge to become directive, especially with individuals who appear to have serious health problems or disabilities, is great. Yet experience indicates that unless workers accurately gauge the capacity of homeless persons to change little can be accomplished. The rule guiding their interaction holds that "too much change too quickly doesn't work." Workers have found that if they push a homeless person who has been on the streets for a lengthy period to enroll in a human service program or make other changes, not only can their relationship with the person unravel, but the person also is likely to reappear on the streets a short time later.

Program Results

During the first year of operation, total program costs were $76,000. The team encountered 650 different individuals, with each receiving at least one service, resulting in a gross average cost of $117 per person. Of the 650 persons, 136 were seen by the team at least five times. Since over 75 percent of the team's time was spent with these 136 individuals, it is appropriate to attribute an equivalent proportion of program costs to these individuals. This results in an average cost of $37 for the 514 persons who for the most part received information and referral assistance from the team. For those who received a more intensive level of service, the average cost was $419 per person. (These figures were derived by simply taking 75 percent of the total costs or $57,000 and attributing these costs to 136 persons, while the remaining costs, $19,000, were attributed to 514 persons.)

Homeless persons served by the outreach program can be divided into two groups. The first and largest group consists of persons who essentially receive information and referral. With regard to the frequency of encounters, these individuals have been seen by the team fewer than five times since the start of the program. They may be new to town or homeless for the first time, and, typically, they use the team to find other services. This group also included a number of persons who exhibit the "end of the month" syndrome. Their finances run out by the end of the month, resulting in a short stay in a temporary shelter or on the streets. The team spends about one-quarter of its time with this group and, in doing so, frequently learns about others on the streets who are opting out or otherwise in distress.

The second group consists of persons who, to varying degrees, exhibit resistance to adopting a client or patient role. They are the primary focus of the program. Each individual in this group has been seen by the team at least five times, with most being seen at least several times each month. Although there are no formal admission procedures, they are in effect the "clients" of the program.

Table 1 compares features of the two groups. Those with fewer than five encounters typically are amenable to receiving help from shelters and other programs for homeless persons. The group with five or more encounters is reluctant to use the service system and consequently is seen more often by the outreach team. Persons who resist the client role tend to be somewhat older. Their median age is 42, compared to 34 for those who have been seen less than five times. The client-resistive group includes a higher percentage of blacks and other minorities, a higher percentage of armed forces veterans, and, not unexpectedly, a much higher percentage of persons who were initially found by the team literally staying on the streets. Among all homeless persons, they appear to be the most disadvantaged.

To evaluate the presence of alcohol abuse or mental illness, the team uses a simple set of

Table 1

Characteristics of Persons Seen: Frequency of Outreach Encounters

Characteristic	Less Than Five Encounters (N = 514)	Five or More Encounters (N = 136)
Age		
Average	32	38
Median	34	42
Sex		
Percent Male	89%	83%
Marital Status		
Percent Now Single	84%	96%
Race/Heritage		
Percent Nonwhite	36%	52%
Veteran Status		
Percent Veterans	26%	34%
Living Arrangement (at first encounter)		
Percent Living on Streets	2%	48%
Disability		
Percent Alcohol/ Drug Abuse	6%	42%
Percent Mental Illness	< 1%	44%
Percent Dual	—	8%

behavioral criteria: self-reports concerning the frequency and amounts of the use of alcohol, frequency of intoxication, expressions revealing disorientation, extreme anger, hallucinations or patently false beliefs, appropriateness of clothing, and self-reports of a history of treatment for alcohol abuse or mental illness. (Note: with only a few exceptions, conclusions drawn by the team based on these criteria have subsequently been validated by a medical examination of those who have agreed to receive help.) As Table 1 illustrates, virtually all of those in the client-resistive group exhibit symptoms of alcohol abuse, mental illness, or both.

To date, the outreach team had served relatively few women. The conclusion has been reached that this low percentage does not mean that there are few homeless women in Milwaukee, but that the program contradicted one of its own guidelines. The data in Table 1 reflect individuals served during the first year when the outreach program was staffed by two men. A review of their case notes and conversations with them revealed that, typically, they had difficulty establishing a minimum level of trust with homeless women despite their persistent efforts. Paul Koegel's paper that summarizes a two-day workshop on homeless women sponsored by the National Institute of Mental Health provides an explanation. Koegel describes factors which precipitate homelessness among women, their characteristics and diversity, the social networks among homeless women, and the strategies they use to survive. One of these strategies is to avoid men. Consequently, within the past month, the outreach program has hired two women. Two teams are now operating in the field, each staffed by a woman and a man.

For the purpose of evaluation, the outreach program measures success by four criteria: (1) present living arrangement; (2) receipt of financial aid or other income; (3) enrollment in a program for the treatment of alcohol abuse or mental illness when appropriate; and (4) receipt of treatment for other medical conditions. These are relatively gross measures that fail to capture incremental changes made by persons seen by the team. A representative example from the case records illustrates this point. In the initial case notes, a man who lived on the streets was described as heavy, weighing more than is ideal for his height. The team also noted that the man wore the same set of clothes in all types of weather. If the man's strategy was to use body odor as a means of keeping people at a distance, he was eminently successful. After repeated contacts with the team over several months, the man decided to go to a shelter, accompanied by one of the workers, to take a shower. Although clearly fearful, he proceeded to take off one layer of clothes after another until he was ready for the shower. The worker was very surprised to see the slight, almost malnourished appearance of the man who was now cautiously entering the shower. Apparently, the man found this experience to be less objectionable than he originally anticipated. At this time, the man continues to live on the streets, but he now regularly asks the team to take him to the shelter for showering and changing clothes.

Table 2 compares the status of individuals at the time of their first and last encounters with the team. The data in Table 2 reflect only those individuals who have been assessed as having a disability and have been seen by the team at least five times.

The data from the program's first year suggest that about four out of five persons seen by the team have made at least one significant change. Over half have either sought a regular source of income through Social Security benefits, veteran's benefits, the local general assistance program, or employment. One-quarter have sought permanent living arrangements, typically in a single room occupancy facility or apartment building. In regard to ongoing care, slightly over one-third now regularly receive some type of treatment, which has been broadly defined to include attendance at Alcoholics Anonymous meetings, other forms of community support, and admission to formal treatment services.

Analysis of the program is continuing in order to compare progress made by persons in different diagnostic and demographic groupings. Other areas being examined include the relationship between the amount or level of outreach intervention and client outcomes over time, and the long-term adaptation of clients in domiciled and undomiciled environments. It is anticipated that the results will help to delineate the characteristics of those who successfully leave the streets, and secondly, to identify and clarify the stages

Table 2

Status at the Time of the First and Last Encounters with the Team
(N = 128)

Criteria	First Encounter	Last Encounter
Living Arrangement		
Temporary Shelter	45%	28%
Permanent Housing	1%	24%
On Streets	48%	32%
Treatment Facility	6%	16%
Income		
Percent without Regular Source of Income	95%	41%
Treatment Program		
Percent Enrolled in CSP/Other Treatment	8%	34%
Other Medical		
Percent Refusing Treatment	68%	24%

of reintegration experienced by persons who have been homeless for an extended period.

Policy Implications

One of the first experiences of the team was with a man who frequented a variety of alleys, abandoned cars, and a freeway underpass. Neither worker was able to make much headway with the man, but both persisted. Finally, the man did allow the workers to get close enough to talk. Their suspicions were realized, as the man's speech contained a high level of delusional and possibly paranoid thought. Unsure as to whether his speech was primarily a way of distancing himself from others or indicative of severe distress, the workers continued seeing the man over a period of several months. Finally, the man revealed that he had been in a psychiatric hospital in the past, had taken medications, and remembered feeling better at those times. The team offered to accompany him to a local psychiatric hospital if he chose to go. He indicated that he would think about it. At the next meeting, the man said he was ready for the hospital. Excitedly, the team helped the man into the van for the trip to hospital. Once there, the team explained the man's circumstances to the hospital staff and then waited nearby while he was examined by the admitting psychiatrist. That day was probably the low point for the team as they heard that "perhaps the man is mentally ill but he doesn't need acute psychiatric care." Having no other option at this point, they returned the man to the alley where they had found him earlier that day. The hospital is a public facility and the largest provider of mental health services for low-income persons in the area. The next day the hospital's administrator was called and an agreement was reached to admit the man. When the team found the man again, he initially refused to return to the hospital, but after several more attempts he did agree to try again. This time he was found to be in need of acute psychiatric care.

One interpretation of this story is that it illustrates the problem of interprogram or interagency coordination when a new service system (the homeless service system) is created because an existing system (the mental health system) does not seem capable of responding appropriately. In Milwaukee, the potential for coordination problems was recognized at the outset, and efforts were made to minimize the frequency of incidents such as this. To achieve a high level of coordination, several tactics were pursued. First, of course, was to expand the makeup of the coalition with representatives of human service organizations in both the public and private sectors. Second was to get active participation with various planning and coordination bodies concerned with homelessness. The director of the coalition spends a significant amount of time working with such groups. The third tactic was to structure the outreach program so that the workers—who act as integrators of the whole range of human services—could become familiar enough with their counterparts in all the organizations providing services to function effectively. These services included housing aid, financial aid, social services, mental health services, chemical dependency services, health care services, and legal aid. Because these efforts had been made, resolving the issue with the hospital was accomplished in a short period. Nevertheless, the fact that it occurred at all suggests that continuous attention to coordination is warranted.

Communities interested in starting or enhancing outreach will have to consider where to locate the program. Should it be located in a mental health agency, a social services department, a housing assistance organization, or a primary health care clinic? The Milwaukee experience suggests that it will make no difference where the program is located if the local service delivery system is poorly coordinated. Because the needs of homeless individuals span multiple delivery systems, outreach will test the effectiveness of the linkages among human service organizations in the public and private sectors. If county agencies are reluctant to share resources and information with city agencies, and with private agencies reticent about working with public organizations, outreach programs, no matter how well conceived, have little chance of helping homeless persons to reintegrate successfully. The federal and state governments can mandate coordinated planning and service delivery, but, ultimately, the responsibility for sharing resources and linking programs rests with city and county officials working with the private sector. If outreach and other efforts directed at homelessness are to succeed, city government, county government, and the private sector will have to jointly define their areas of responsibilities and the linkages among programs. Collaborative sponsorship of programs exemplified by Milwaukee's coalition is one approach to achieving organizational coordination. The next step is to devote specific staff resources to coordination in order to facilitate sharing at the day-to-day, operational level.

In a broader sense, the incident at the psychiatric hospital reflects the inappropriate application of the acute care model to problems that require long-term, sustained intervention and support. The mental health system offers this model of care, not out of choice, but as a reaction to federal and state policy. The admitting psychiatrist's original opinion was perhaps correct given the constraints faced by psychiatric facilities today. The man didn't need acute psychiatric care. The team anticipated that a stay in the hospital would be only the first, small step in a long road of recovery from a homeless lifestyle.

Yet, so much attention is devoted to enrolling persons in a system that operates with a short-term model. As Koegel points out, the attitude of the service system seems to be "if chronically mentally ill homeless persons would only take their neuroleptic medication on a regular basis, they would no longer be homeless." The outreach program has worked with several people who have agreed to take neuroleptic medications, who take them on a regular basis, and who are still homeless. Acute psychiatric care as provided today is only one small part of the solution. Why then have so many mental health providers adopted the acute care model?

As indicated earlier, the Milwaukee outreach program is based on the results of a research project. When proponents of the program first approached local officials responsible for long-term, community-based mental health programs, the initial response was enthusiastic. The interest of these officials soon waned, however, when they realized that the program could very well generate additional demand for placement into long-term programs such as residential care, vocational related training and work activities, and community support. Their response was clear: Long-term programs are full, what are we going to do with more clients? The most they could promise was acute care—diagnosis, medication prescription, and monitoring. Because of quick turnover of persons seen in acute care, there are almost always openings. Perhaps most importantly, acute care services for certain patients can also be billed to third parties or Title XIX (Medicaid). Long-term support, however, in a supervised group home setting, is not eligible for third-party reimbursement.

Local public and private agencies can coordinate, but without adequate state and federal financial support, they will be coordinating phantom systems. During the past decade, as the federal government has squeezed mental health funds for long-term care, so have the states. The result is the dominance of a model of care which, at its best, addresses only a small portion of the needs of homeless persons. If there has been a federal policy, it is that mental health care is a state or local responsibility. Now, with at least 50 different policies throughout the country, is it surprising that the mental health system has been slow to respond to the problem of homelessness? Is it surprising that a psychiatrist under pressure to reduce lengths of stay in a hospital would not admit a man who undoubtedly would consume considerable resources over an extended period? Is it surprising that local officials in charge of long-term care services filled to capacity would be less than enthusiastic about reaching out to find new clients?

When the federal government started to relinquish its responsibilities in the areas of mental health, social services, housing, financial aid, work training, and vocational education to the states, it sowed the seeds of homelessness on the scale seen today. Now, governments are in the process of creating a new, alternative service system, the homeless service system, to care for those who are falling through the safety net. There is a choice before state and federal policymakers today. They can continue to build this new system through such efforts as the *Mckinney Act*. If this policy is pursued, an unintended consequence will be to make homelessness a long-term phenomenon as service systems gain momentum by their sheer existence. Persons in need and providers to serve them will flow to where the dollars can be found. Although this creates coordination problems at the local level, it certainly is better than doing nothing. Or, states and the federal government can renew a commitment to provide leadership and financial support for mental health care and these other basic services.

Conclusion

For homeless persons who resist the client or patient role, outreach is a viable means of engaging them in a process whereby their needs for housing and treatment can be met. However, several cautionary warnings are directed at local governments interested in starting or expanding outreach efforts. Outreach is not a ruse for quickly eliminating homeless persons from certain areas of the city. A value orientation which recognizes the importance of building trust and sharing power is a necessary antecedent for the successful implementation of outreach. Working with client-resistive individuals is a slow, painstaking process. Those expecting quick results are likely to be disappointed. A second, necessary condition for successful implementation is a well coordinated human service system with operational linkages among public and private sector agencies. Outreach will reveal poorly planned linkages among agencies and programs.

Homelessness among severely mentally ill persons, chronic alcoholics, and other chemically dependent persons represents a failure of state and federal policy to adequately sustain long-term community support systems. Mental health service systems, for example, can offer acute care, but are hard pressed to meet the volume of demand for long-term care. Recent state and federal policy directions are stimulating the creation of new funding mechanisms and service delivery systems, rather than preventing homelessness by bolstering basic community resources for the long-term care of disabled persons.

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Homelessness and the New Federalism: The Westchester Experience

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The vaunted "safety net" of the New Federalism is riddled with holes, and the outlook for the poorest of our nation's poor is ever bleaker. Paradoxically, these developments come during the nation's longest peacetime economic expansion. Inflation has been brought under control and more Americans than ever before are employed. True, our budget and trade deficits hang over this prosperity as twin Damoclean swords, but even our financial markets have recovered from last October's crash and settled at levels comparable to those of just over a year ago.

America's fundamentals are sound, but an image crisis persists. Most Americans are better off than they were when the 1980s began, while poor Americans are generally worse off. No sign of our times is more telling than the historic number of Americans who are homeless. No sign of our times is more indicting of our failure to combat poverty than translation of the American dream of home ownership into a national nightmare.

Why is the County Executive of Westchester, New York concerned about poverty and homelessness. To be truthful, when I assumed this office over five years ago, I never imagined I would be required to become an expert on the intricacies of the welfare system.

Westchester County is a near microcosm of the United States. Westchester, with a population 870,000, is a wealthy suburb of New York City. The county is home to 17 symphonies and the headquarters of several Fortune 500 corporations. Westchester residents enjoy a per capita personal income that puts the county in the top ten. Average home prices of $340,000, four-acre zoning in the northern towns, country clubs, golf courses, and miles of riding trails reinforce our image as a haven for the well-to-do.

Our population is fully employed; that is, more than 50 percent work and unemployment is less than 3 percent.

These enviable indicators of wealth are only one side of the Westchester story, however. Yonkers, the fourth largest city in the state has received an adverse judgment in a painful, eight-year housing segregation case. Older urban communities are also found in Westchester's five other cities and in villages like Ossining on the Hudson River and Port Chester on Long Island Sound.

On the one hand, this blend of urban centers, suburban developments, and open rural areas has fueled our prosperity. On the other hand, it has also ensured that not all of our 870,000 residents enjoy a country club life.

One such resident was Vincent Edward Odom, born August 1, 1968, in the City of Mount Vernon. He grew up there, except for a few months when his mother moved the family to Virginia. He began his secondary education at Mount Vernon High School; he was a sophomore there when his mother, Comora, lost their family apartment. The Westchester County Department of Social Services placed the Odoms in a motel room in the Village of Elmsford, a community less than two miles square about 15 miles northwest of Mount Vernon.

Vincent Odom left his motel room each school day to attend classes at Alexander Hamilton High School in Elmsford. When he was not in school, he was working 40 hours a week as a security guard at a telephone company facility. He worked the tough shifts that no one else wanted—four-to-midnight on Mondays and Fridays, evenings and nights on the weekends. One Saturday in January, he returned to the motel room "not looking very well," according to an aunt who was visiting. He went to bed and never woke up again. He was 19 years old and was in his senior year in high school.

The medical examiner ruled that Vincent Odom died of gastrointestinal bleeding caused by an ulcer that no one knew he had. The coroner's report was not the end of the Vincent Odom story. More than 50 of his classmates and many faculty members attended the memorial service for Vincent at a funeral home in Mount Vernon. That is how most of them found out that this hardworking and obviously well-liked student was homeless. He had been careful not to tell anyone. The reason? The Village of Elmsford has been up in arms over the placement of 180 homeless families in motels and hotels within its boundaries. Tempers at meetings of the village board have run hot. The only emotions at the funeral home in Mount Vernon were grief and sorrow.

The editorial writers of Gannett Westchester Newspapers put it best: "Vincent Edward Odom didn't freeze to death on a sidewalk grate clutching an empty wine bottle . . . [he] carried a full high school class load . . . also held a full-time 40-hour-a-week job. . . . And, through no fault of his own, he was homeless."

Comora Odom and her son Vincent are not Westchester's only crisis. They were but two of the 3,973 homeless persons to whom the county provided services las January. Almost half of these individuals (1,739) were the children of 862 families.

For Westchester County government, homelessness is a costly, frightening, and frustrating problem:

- Costly, because just five years ago the county spent only $750,000 a year on homelessness; this year we are budgeting over $54 million;
- Frightening, because we are damaging, perhaps irreparably, more and more children each year; and
- Frustrating, because the county government has no powers over land use or permanent housing, yet it is responsible for emergency housing and social services.

Westchester's homeless are the victims of a system which does not work because it cannot work. Fifty years ago, New York State adopted a constitution whose Article XVII requires the state legislature to provide for the needs of the poor. Outside of New York City, social services are the responsibility of county governments, which must also raise a large share of public assistance funds. The same constitution delegates the state's police powers over land use to cities, towns, and villages, but not to counties. Moreover, Article XVIII of the state constitution excludes counties, by omission, from those local governments granted public housing powers.

Historically, Westchester's Department of Social Services, like the departments in other counties, has provided cash assistance to families and arranged services. The agency was never intended to be a direct provider of services. The homeless crisis has changed all that. Not only must the department provide more and more services directly to clients, but the department must also now develop resources, particularly emergency housing. The department cannot, however, participate in the development of permanent public housing because of the constitutional ban.

Clearly, the division of authority among local governments in New York State does not reflect the division of responsibility. What made sense 50 years ago simply does not work today. Cities, towns, and villages jealously guard their home rule prerogative to control land use, and they have no political incentive to construct housing affordable to low-income families because the cost of providing emergency housing is borne by the federal, state, and county governments. Moreover, the federal financial

incentives that once spurred the development of affordable housing are almost gone. We will be lucky to preserve a spending level of $8 billion for housing in next year's federal budget, down from $30 billion at the beginning of this decade.

New York State's system fails to work at the regulatory level as well. In January 1988, Westchester's homeless population included 272 school-age children who were placed in motels as far as 75 miles from their home school district. The New York State Department of Social Services requires local departments of social services to maintain, insofar as possible, a family's ties with its home community. As a result, the county spends well over $1 million a year to transport these children, sometimes by taxi, back to their home school districts. The travel time is long, and the trips are onerous for these young children. Often, they arrive exhausted and unable to concentrate on their schoolwork, compounding the disruptions in their lives caused by homelessness.

One obvious solution is to enroll children in the school districts where they are temporarily residing. This right is not now guaranteed by New York State Education Department regulations, although a proposal to allow parents to choose the district in which the homeless child will be educated is pending before the Board of Regents. In the meantime, a potential "Catch 22" persists for the homeless school-age child. The school district of origin can take the position that a child who is not currently living in the district is not a resident there. The school district of temporary residence can take the reverse position, that a child who has a temporary address, such as a motel, is not a resident of that district.

Why this sorry state of affairs exists is best summarized by a federal district court judge who was asked to order a home district to enroll a child:

> "The failure of legislative and/or regulatory leadership on this issue is at the center of this action," Judge Gerard L. Goettel wrote. "Perhaps in this age when legislators won't legislate and regulators won't regulate, preferring instead to spend their time carping at federal judges who ultimately must step into the breach to protect individual rights from the capriciousness of ad hoc decisionmaking, one should not be surprised at this state of affairs."

Judge Goettel makes a telling point larger than the issue in that particular case: in this era of leadership by opinion poll, the statesmanship necessary to adjust government systems to cope with new problems is in short supply. At all levels of government, officials seem unwilling to take even prudent risks, preferring instead to make minor changes in what exists.

Helping Displaced Families and At-Risk Families

Westchester County faces serious systematic and historical constraints on its ability to help homeless families and families at risk of becoming homeless. We have, nonetheless, fashioned a number of innovative programs that work despite existing restrictions.

Eviction Prevention

Eviction from the family's primary residence is the leading cause of homelessness in the county, accounting for roughly one in three cases. A successful policy to prevent evictions would save families from enduring the nightmare of homelessness and the disruption of an emergency placement.

Like other densely populated communities, Westchester County has seen tens of thousands of rental units converted to cooperatives and condominiums during the past 10 years. Our rental housing vacancy rate, which three years ago was considered low at 2 percent, is nearly zero today. Average rental costs for two-bedroom apartments range from a low of $650 to $750 a month in our northernmost city, Peekskill, to a high of $825 to $1,250 a month in our center city of White Plains. The state shelter allowance for a family of three is $361 per month; for a family of four it is $393 per month. The Section 8 fair market rent for a family of four is $642 per month. The widening gap between available assistance and market rents, especially for people on public assistance, forces eviction from their apartments.

The Westchester County Department of Social Services often learns much too late of a family's legal troubles with a landlord. Once an order to quit the premises has been granted by a judge, it is impossible to negotiate a one-time payment in full satisfaction of rental arrears with the landlord. Timely notice to the Department of Social Services would be a big help, but the major obstacle is that Westchester County has no unified court system to handle eviction cases. Local courts in each of our 45 cities, towns, and villages handles tenant/landlord disputes, including eviction proceedings.

Through the initiative of a citizen member of the County Commission on the Homeless, we have recently implemented an experimental program to prevent evictions. The administrative judges of the Yonkers and Mount Vernon city courts have agreed to notify the local social services office of all impending eviction proceedings, and the county Department of Social Services can then determine which of the eviction cases involves public assistance recipients without violating confidentiality.

At a cost of $57,000, the county contracted for one-year with the Westchester Mediation Center,

Inc., a nonprofit group, which will provide two trained staff members to attend eviction proceedings. These mediators are responsible for working out an agreement between the client, the landlord, and the Department of Social Services to preserve the client's tenancy. The program is operational in Yonkers and will be expanded to Mount Vernon. Given the high cost of motel placements—an average of $36,000 a year per household—preventing just two evictions of a three-to-four-member household each year will pay for the cost of the program. Our best guess is that we can prevent three evictions a week in these two city courts and pay for the program many times over.

This approach is just one example of the tremendous amount of untapped creativity in the private and nonprofit sectors. To encourage sustained thinking on how to better attack homelessness at an early stage, the county also established a $1 million fund and circulated a request-for-proposals for pilot programs to prevent homelessness. Initial responses came from 15 private agencies from every branch of human services—housing developers, health centers, community action programs, a legal services agency, and a child protective services agency—for a total of $1.7 million in funding requests. There is no lack of creativity when you keep the red tape to a minimum and provide some funds.

Section 8 Homeless Referral Program

The Department of Housing and Urban Development's Section 8 program is by far the most important mechanism for getting homeless families into permanent homes and maintaining them there. It allows use of the existing housing stock and allows clients to select their own apartments.

There are 18 different municipal agencies in Westchester County with jurisdiction over the Section 8 program, including the county Department of Planning's Division of Housing and Community Development. In response to the worsening homeless crisis, the Department of Planning's Section 8 office has developed the Homeless Referral Program to assist eligible families in obtaining vouchers and certificates. In the past year, more than 200 families have been helped, saving the Department of Social Services over $3 million in payments for motel room.

The program is simply a systematic process for getting the client through all the red tape. The client remains responsible for finding an apartment, after which the Department of Social Services caseworker and the local Section 8 office are immediately dispatched to evaluate it. Their approvals produce a prompt and thorough inspection by Westhab, Inc., a nonprofit development corporation that specializes in shelters and residences for homeless persons. Westhab's assessment is based not only on physical conditions but also on the needs of the client, the reasonableness of the rent, and the availability date of the unit. The Social Services caseworkers then authorized to arrange for the final move and to pay the security deposit. Once the client has found an apartment, he or she has to deal only with the Homeless Referral Program worker to secure the apartment. The elimination of many steps in the bureaucratic process is a key to this program's success.

Westchester HELP

In January 1988, there was a major breakthrough in Westchester's drive to develop transitional housing for homeless families. What seemed like a conspiracy of silence on the part of local officials was shattered when the Mayor of Mount Vernon, the supervisor of Greenburgh and the mayor of White Plains pledged their support for three sites with a total of 208 units. A fourth site for 50 units was offered by a nonprofit child care agency.

These offers were made in response to a request for proposals issued in October 1987 by Westchester County and HELP, Inc. (Homeless Emergency Leverage Program), a nonprofit developer of transitional housing for homeless families. Governor Mario Cuomo's support made this program a bipartisan effort to grapple with the state's worst homeless problem outside New York City.

What makes this program unique is that, after 10 years of operation, the transitional housing will be turned over to the local government for one dollar for permanent housing. Our request for proposals suggested that the specified permanent housing use be for senior citizens or other special needs groups, like municipal employees who are priced out of Westchester's housing market.

Housing is not the only key component of a Westchester HELP facility. Each project will be what is defined by New York State regulations as a "Tier II" family shelter. This means that the Department of Social Services will contract with a nonprofit operator to provide intensive and coordinated social services at the facility for the 10-year period.

Westchester's homeless families will get much more than a place to live. Special needs, such as child care, employment counseling, therapy, searching for permanent housing, will be met on-site. Displaced families will benefit from a more humane setting than a motel room—each unit is equipped with a kitchen, bathroom, and separate sleeping area—and from intensive case management, which will shorten by half the average length of stay in emergency housing. Westchester's taxpayers will benefit because the comprehensive services package that is delivered along with the emergency housing will be the same price that we now pay for motel rooms.

Homeless Services Network

Westchester is not waiting for specially designed facilities to come on-line to deliver coordinated services to families whose lives have been disrupted by homelessness. Motel rooms are terrible places for families and children in and of themselves, but the lack of normal family supports usually available in society's mainstream is even more damaging. The county Department of Social Services worked hand-in-glove with a network of private agencies—including the Center for Preventive Psychiatry, the Family Service Society of Yonkers and the Yonkers Youth Connection—to bring needed support services for homeless families together under one roof.

The Homeless Services Network is akin to a day care center for the entire family. Hot meals are provided along with child care to enable the parent(s) to search for permanent housing and employment. Counseling is also readily available, and the services package is tailored to suit each family's needs. This program has been operating since January 1987 and has reduced the length of homelessness by as much as one-third. Families benefit by not having to travel to and wait at many different locations for needed services. The county benefits by a quicker return of the family to permanent housing.

The Federal Regulatory Climate: Help or Hindrance?

The programs I have just highlighted are our success stories: they use creativity in arriving at new approaches to the problem of homelessness in spite of many restrictions and constraints. I use the term "creativity." Others have described our efforts as "circumvention," but more about that later.

Section 8 Restrictions

Earlier, I described the Section 8 program as the best method we have at our disposal to return displaced families to permanent housing. Section 8 assistance comes in two forms: the tried and true certificates and the relatively new vouchers. The program is designed to supplement rent payments for families whose income is below the poverty level and who pay more than 30 percent of their income for rent.

Vouchers have become popular because they are more flexible than certificates. The household being assisted can choose to pay the difference between the market rent and what Section 8 will allow from the income remaining after they have put 30 percent of it toward rent. In cases where the gap is relatively small, this is an important advantage without too serious an impact on the family. The proof that this approach works is that our current allotment of almost 200 vouchers is fully utilized and we have a long waiting list for any supplemental allocations we may receive. The danger of the voucher program, though, is that as market rents continue to rise, families with a Section 8 voucher will one day be forced to choose between paying rent and buying food because they are not limited on the percentage of income they can spend on housing. True, that day is much farther away for a Section 8 family than for a public assistance shelter allowance family, but in tight housing markets, vouchers only postpone this difficult choice, they do not eliminate it.

The use of Section 8 certificates, on the other hand, is severely constrained by the low Fair Market Rents (FMR) for Westchester County by the federal government. Today in Westchester, the 18 agencies with jurisdiction over Section 8 housing have a total of more than 1,000 idle certificates. The reason is simple: if the apartment to be rented is even one dollar above the FMR, the certificate cannot be used for it at all.

Presently, Westchester County is considered part of the New York City Primary Metropolitan Statistical Area for the purpose of determining FMRs. We have regularly received the 20 percent exception permitted under the program's guidelines, but even these levels, which are based on broad regional evaluations rather than our local market conditions, are just too low to be useful. Until last month, our FMR for a two-bedroom apartment was $564—well below average rents for nonluxury units.

At any time, the U.S. Department of Housing and Urban Development (HUD) could, by executive fiat, revise the method by which Westchester's FMRs, as well as those of any other region, are calculated. They have been reluctant to do so, despite the glaring inconsistencies in the system. Their refusal has prompted a review by the General Accounting Office at the request of Sen. William Proxmire. While in Westchester, FMR levels result in 1,000 idle certificates, in certain parts of Texas, FMR levels result in a bonanza for landlords because market rents are at a substantial discount to the FMRs.

Westchester has succeeded, however, through the efforts of Rep. Joseph Dioguardi, in obtaining legislative relief that requires HUD to calculate FMRs separately for our county. This process is now under way, and we expect to obtain an average increase of $100 to $200, which should make a good portion of our idle certificates usable.

EAF and AFDC Restrictions

Westchester County has taken full advantage of a practice now permitted under the Emergency Assistance to Families (EAF) program to prevent homelessness, even among families who are not presently eligible for public assistance. The Department of Social Services uses EAF funds to make a one-time payment to landlords or utility companies

to prevent evictions of families with children. Current regulations allow federal matching of 50 percent of the cost authorized by the state during one period of 30 consecutive days in any 12 consecutive months, *even if the payments are to meet needs which arose before the 30-day period or are for needs which extend beyond the 30-day period.* This program has been particularly useful in preventing homelessness for families not on public assistance when threatened with eviction, but who most certainly would be on public assistance if they were evicted and placed in a hotel or motel.

Regulations governing the Aid to Families with Dependent Children (AFDC) program permit the establishment within each state's standard of need of "special needs" allowances. In addition, these regulations provide for 50 percent federal participation in the cost. Special needs allowances for emergency housing provide almost all the funding for transitional and emergency housing for families in Westchester. This mechanism is also the cornerstone of funding for Tier II Family Shelters and the Westchester HELP project. The county has used this funding stream successfully to bring almost 190 emergency apartments under contract to the Department of Social Services, 70 of which have been rolled over into permanent housing for public assistance recipients at normal shelter allowance rates.

On December 14, 1987, the administrator of the Family Support Administration in the U.S. Department of Health and Human Services published proposed regulations in the Federal Register that would restrict the use of EAF funds to cover expenses incurred for a single 30-day period and limit the states' authority to make payments for special needs of AFDC recipients for shelter. Congress has prohibited the secretary of Health and Human Services from taking any action would have the effect of implementing, in whole or in part, the proposed regulations through a provision in the *Omnibus Budget Reconciliation Act of 1987.* Should they be implemented, Westchester would stand to lose not only about $11 million in federal reimbursement but also its ability to assist families at-risk of becoming homeless. In addition, the county's ability to develop new resources would be seriously limited.

We do not believe that the secretary has the authority to implement the regulation on special needs. The United States Supreme Court has ruled, based on explicit statements contained in the legislative history of the *Social Security Act of 1935,* that each state is free to set its own standard of need and to determine the level of benefits by the amount of funds it devotes to the program, *Kings* v. *Smith,* 392 U.S. 309, 318-9 (1968). We believe the proposed regulation runs contrary to congressional intent—because it infringes on a state's latitude to determine its standards of need—and contrary to the Reagan administration's fervent advocacy of states' rights as guaranteed by the Tenth Amendment.

One final thought on AFDC regulations relates to the fact that these funds presently may not be used for any capital costs. This is the basis on which HHS recently disallowed millions of dollars spent by New York City on its emergency apartment rehabilitation program. Assuming that the states prevail on special needs funding, it makes absolutely no sense to allow a state to spend almost limitless sums of money on emergency housing while prohibiting a state from diverting some of those wasteful expenditures into the construction of desperately needed permanent housing affordable to low-and moderate-income households.

The McKinney Act

To its credit, the Congress made a major effort last year to provide emergency relief to the nation's homeless. Over $1 billion was authorized for fiscal years 1987 and 1988. Unfortunately, the entire amounts were never fully appropriated. The present spending level is about one-third less than the authorization. The *McKinney Act* must also be taken in the context of the entire federal commitment to housing-related issues—$1 billion over a two-year period is a significant amount, until you compare it to the more than $20 billion a year in federal housing assistance lost in recent years.

McKinney Act programs must be reauthorized for the 1989 fiscal year. They are competing with proposed increases in expenditures for education, space and science, and all other discretionary domestic spending, which is allowed to grow by only 2 percent under the terms of the budget summit agreement of last fall. The prospects for substantial assistance are bleak, though any amount will be welcome.

The *McKinney Act* emergency shelter grant program yielded an allocation of just $70,000 to Westchester County government, despite the fact that we have the largest census of homeless persons in New York State outside of New York City. These funds were distributed pursuant to the community development block grant formula, which targets money away from regions with low unemployment and other favorable economic indicators. The county's funds were put to good use by awarding them to existing organizations to expand services: $15,000 to the White Plains YWCA to create three additional rooms for homeless women and repair 29 existing rooms; $35,000 to Westhab, Inc., for emergency apartment development in Yonkers; and $20,000 to the Grace Church Community Center in White Plains to add seven new beds to their Samaritan House shelter. Each agency was required to match

these grants with their own funds, thus thereby increasing the leverage. However, Westchester probably spent close to $70,000 in staff time preparing submissions to receive these funds and then disbursing them. Furthermore, the short lead time for preparing submissions stifled original thinking.

Conclusion

From the illustrative examples in this paper, I have tried to lead the reader to the following conclusions:

1. Homelessness is a national problem. It is not limited to big cities and urban centers. Paradoxically, it may increase in severity as a region's prosperity grows.
2. America's homeless are not just the stereotypical derelicts. Many are children, very young children, and many are struggling to be productive members of society.
3. Homelessness exacts a terrible toll on its victims at a tremendous cost to the nation's taxpayers.
4. Existing social welfare systems are ill-equipped to deal with this phenomenon on so large a scale.
5. Leadership by national and state officials is desperately needed to adjust our systems to respond to this crisis rather than to make cosmetic changes in existing practices.
6. Local governments, on the front lines of delivering services, are best equipped to tailor assistance programs to meet local needs, but they are constrained by regulatory inflexibility.
7. Limited federal resources are not being directed to the areas of greatest need because of reliance on standards that are not applicable to this crisis and fail to account for the differing divisions of responsibility and authority in each state.

As a realist, I believe that state and local officials must recognize that the 1990s will be marked by federal preoccupation with the budget deficit, precluding any major federal reinvestment in housing. However, I also believe that, since 1935, Congress has set a national policy of protecting children from the scourges of poverty. Inherent in that protection is a right to a decent, safe, and permanent address that a child can call home. Our national interest is not well served by raising a generation of motel kids; such a waste of human and fiscal resources would be sinful. By making changes in the existing programs that have been spared the federal budget axe, by redesigning some state systems, and by encouraging responsibility in homeless adults to take charge of their reentry into society's mainstream, I believe we can save the next generation of poor children from this growing national tragedy.

Health Care for the Homeless: The Challenge to States and Local Communities

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For good or ill, the problems of the nation's homeless have forced themselves onto national, state, and local political agendas.[1] Locally, the most publicized initiative has been in New York City, where Mayor Edward Koch has ordered involuntary commitment to treatment for those mentally ill homeless persons whose lives and well-being are potentially in some danger owing to their lack of shelter. This move was resolutely opposed by most civil libertarians and homelessness advocates.

At the national level, some 32 separate bills were introduced into the 100th Congress addressing some aspect of homelessness, and a similar number will no doubt be considered by the 101st Congress. These 32 bills, if enacted, would disperse federal responsibility for the homeless over a wide range of agencies and departments; the result would be less a coherent federal policy on homelessness than a diverse array of programs, each targeted to a subset of the larger population. There would be, for example, separate programs for homeless veterans, families with children, alcohol abusers, teenagers, the mentally ill, and so on.

Among the many problems faced by homeless people, poor physical health is among the most visible and important, surpassed perhaps only by problems of securing shelter and adequate nutrition. The importance of health issues to the homeless is recognized in the *1987 Stewart B. McKinney Homeless Assistance Act*, which includes a rather substantial health care component. Aside from the direct need for primary health care, attention to physical health may also play an important role in attempts to address many other problems. Many homeless people are simply too ill to obtain or maintain employment or to be placed in counseling and job

training programs. Some are too ill to stand in line while their applications for benefits are being processed or too sick to search for housing within their means. Thus, health issues are rightly found at or near the top of the agenda among persons working with the homeless.

The homeless suffer all the ills to which the flesh and spirit are prey, but the onset, etiology, progression, and severity of those illnesses are magnified by the disordered and uncertain conditions of a homeless existence. There is scarcely any aspect of homelessness that does not compromise physical health or at least greatly complicate the delivery of adequate health services.[2]

The major features of a homeless existence that have a direct impact on physical well-being include an uncertain and often inadequate diet and sleeping location, limited or nonexistent facilities for daily hygiene, exposure to the elements, direct and constant exposure to the social environment of the streets, communal sleeping and bathing facilities (for those fortunate enough to avail themselves of shelter), unwillingness or inability to follow medical regimens or to seek health care, extended periods spent on one's feet, an absence of family ties or other social support networks to draw upon in times of illness, extreme poverty (and the consequent absence of health insurance), high rates of mental illness and substance abuse, and a host of related factors. It has been said, therefore, that the homeless may well harbor the largest pool of untreated disease left in American society today.

The extreme poverty of the homeless population also severely limits access to health care, as does the general estrangement from society and its institutions.[3] A recent study in St. Louis showed that more than 70 percent of the city's homeless had no regular health care provider and that more than half had not received any health care attention during the previous year. Much of the health care the homeless do receive is through hospital emergency rooms.[4] Virtually all major cities have emergency shelters where anyone without housing can at least get out of the rain for the night; likewise, no city is without its soup kitchens and food banks where anyone who needs it can get a free meal. Even so, where can a person with no home, no family, no medical insurance, and no money go to get health care?

The National Health Care for the Homeless Program

In 19 major U.S. cities, a homeless person might go to the local Health Care for the Homeless (HCH) project. In December 1984, the Robert Wood Johnson Foundation (Princeton) and the Pew Charitable Trust (Philadelphia), in conjunction with the United States Conference of Mayors, announced grants totaling $25 million to establish Health Care for the Homeless demonstration projects in 19 of the nation's 50 largest cities.[5]

Most of the 19 projects are community-based health care stations in facilities used by homeless persons—shelters, missions, food outlets, and the like. Homeless and destitute persons receive first aid, screening, assessment, and primary health care, as well as referrals for the evaluation and treatment of more difficult or complicated health problems. Virtually all homeless persons who come in for treatment receive it, regardless of their ability to pay, insurance coverage, physical appearance, or mental condition.

Although the focus of the program is primarily on physical health, it is recognized that these problems cannot be dealt with adequately without concern for a much larger range of issues. Health care teams consist, minimally, of doctors, nurses, and social workers or other appropriately trained persons acting as service coordinators. The projects' responsibilities specifically include arranging access to other services and benefits, for example, job finding, food or housing services, and benefits available through public programs, such as disability, worker's compensation, Medicaid, or Food Stamps. The underlying concept is to use health care as a "wedge" into a much broader range of social, psychological, and economic problems.

From startup through the end of September 1987, the program documented about 241,000 contacts with about 85,000 clients. Information on each of these meetings and clients is gathered in a more or less standardized fashion and is submitted to the Social and Demographic Research Institute for processing, coding, and entry into a master data base. This paper summarizes the experiences of the HCH projects during the first two and a half years of operation, as recorded and documented in our data, and discusses their implications for state and local governmental responses to the health care needs of the homeless.

HCH Clients and Their Health Problems

Clients

Many recent studies have shown that today's homeless persons are very different from those of earlier eras. Indeed, the phrase "the new homeless" has come into currency to help stress those differences.[6] The "old homeless" were often in that situation because of personal failings, principally alcohol abuse. The "new homeless" tend instead to be victims of large-scale trends in the political economy of the nation: the continuing loss of low-income housing and the gentrification of urban areas, persistent problems of unemployment and underemployment, large-scale changes in treatment of the alcoholism and mentally illness, continuing

declines in the vitality of the nuclear family, reductions in social welfare spending, and a host of other factors.[7]

The social and demographic profile of HCH clients is generally very similar to that reported in other recent studies. The average (median) age of HCH adults is barely 34 years; nearly three in eight are women, children, youth, or members of homeless family groups. (Ten percent of the clients are younger than 16 years old.) All racial and ethnic minorities are heavily overrepresented; the elderly (ages 65 and over) are sharply underrepresented. In all these respects, the "average" HCH client cannot be distinguished from the "average" homeless person in America today.[8]

This, of course, does not imply that the HCH client base can be taken as a "representative" sample of the urban homeless. First, virtually none of the 19 projects attempt to screen clients for homelessness; that is, not all clients are literally homeless, at least not by some definitions.[9] Perhaps more importantly, the sample is largely self-selected, consisting only of people who, for whatever reason, saw fit to present themselves for medical attention to the HCH project teams. As it happens, however, the self-selection bias appears to be rather small.[10] This suspicion, plus the large sample size and wide geographical dispersion, suggest that the HCH client data can be taken as indicative, if not strictly representative, of the larger homeless population of the country.

The demographic characteristics of HCH clients demonstrate an important point, namely, that the homeless comprise a very heterogeneous population of men and women, young and old, white and nonwhite. One important source of heterogeneity (among clients and the homeless in general) is the nature of their homelessness, whether chronic or episodic. Many studies have revealed a mixture of chronic long-term and transitory short-term homelessness, and in this report, HCH clients are again no different. Results for a sample of HCH clients seen during the first year showed that only 29 percent were chronically homeless (that is, more or less continually homeless for an extended period). Most clients (52 percent) were assessed as episodically homeless (recurring periods of homelessness punctuated by occasional and variable periods of stable housing); the remainder (19 percent) were recently homeless for the first time (such that no pattern had yet been established). These patterns are similar, for example, to those reported by Peter H. Rossi in the survey of homeless persons in Chicago. In that study, 31 percent had been homeless for less than two months and 25 percent had been homeless for more than two years.[11]

Health Problems

Data on health problems presented by HCH clients show that the homeless suffer most disorders at a much higher rate than that observed among ambulatory health care patients in general.[12] The leading health problem is probably alcohol abuse, followed by mental illness. Consistent with other research, we estimate that 38 percent of the clients (47 percent of the men, 16 percent of the women) have an alcohol problem, which is three or four times the "rule of thumb" estimate for the U.S. population as a whole. Concerning mental health, about one-third have significant psychiatric problems; these problems are more common among homeless women than homeless men.[13] The alcohol abusers and the mentally ill also show elevated rates of most physical disorders as well.[14]

The most common physical health problems encountered in the projects are acute episodic disorders: specifically, upper respiratory infections, injuries, and skin ailments, in that order. The principal chronic or major disorders, also in order of frequency, have been hypertension, gastrointestinal ailments, peripheral vascular disease, dental problems, neurological disorders, eye disorders, cardiac disease, genito-urinary problems, musculoskeletal ailments, ear disorders, and chronic obstructive pulmonary disease. Overall, we estimate that 41 percent of the HCH clients are afflicted with some chronic physical disorder, compared to 25 percent of the U. S. ambulatory patient population in general. Although some share of these elevated rates can be ascribed to demographic or behavioral factors (especially to the relatively high rates of alcohol abuse), the larger share can only be ascribed to the condition of homelessness itself.

As already stated, a tenth of the HCH clients have been children; about 15 percent of them exhibit one or another chronic health problem. This is about twice the rate of chronic disease observed among ambulatory children in general. Likewise, a tenth of the women clients have been pregnant at or since their first contact with HCH. The highest pregnancy rate is for HCH women of ages 16-19.

The research also suggests that about one homeless client in six is afflicted with an infectious or communicable disorder that represents some potential risk to public health. Most of these disorders are minor conditions: skin ailments, lice infestations, and the like. Still, serious respiratory infections (pleurisy, pneumonia, influenza) are observed among more than 3 percent of the clients; sexually transmitted infections, among about 2 percent; and active pulmonary tuberculosis, among about .5 percent. The rate of tuberculosis infection among the homeless greatly exceeds that of the general population.[15] Since homelessness is clearly not a "closed system" within which disease processes are readily contained, it is obvious that the "population at risk" from infectious and communicable disease borne by the urban homeless is not coterminous with the urban homeless population itself. Other homeless people

are probably at the highest risk, but so too is the larger public.

This is not to suggest, of course, that homeless people be quarantined in order to protect the health of everyone else or that bells be hung around their necks to alert the healthy to their approach. The short-term or "ameliorative" solution to this particular problem is thorough, aggressive screening for communicable disorders among the homeless and adequate medical treatment for those found to be afflicted. In the long run, the principal solution to the health risks posed by the condition of homelessness is to eradicate the condition itself.

Our results and those reported by others leave little doubt that homeless people need better health care than they normally receive. Many look to Medicare and Medicaid for the solution to this problem, but this proves not to be adequate. First, program-wide, only about half the HCH clients receive any form of entitlement or assistance, chiefly welfare, Medicaid, and Food Stamps. This proportion is extremely variable across projects—ranging from 22 percent to 82 percent—so summary statements can be misleading. (The variation across projects results largely from state policy differences in the stringency of eligibility criteria.[16]) As the General Accounting Office has pointed out, "Medicare is only for aged or disabled persons with work histories. State Medicaid eligibility rules are often contingent upon eligibility for AFDC or SSI, or even stricter standards."[17] Indeed, our best estimate is that only about a quarter of HCH clients are eligible for Medicaid and fewer than a tenth are eligible for Medicare. The proportion of homeless people whose health care needs are not met by existing programs is therefore on the order of two-thirds.[18]

Policy Implications

What are the implications of the Johnson-Pew HCH program for states and local communities in an era of retrenchment?

The Homeless Can Be Reached

Perhaps the most important lesson is that it is at least possible to engage the urban homeless in a system of health care, that something *can* indeed be done to address the health needs of this underserved segment of the urban poverty population. It is useful to stress that before the experiences of the Johnson-Pew program, this was not obvious. The homeless, it was frequently said, were too hostile toward institutions, too suspicious and disaffiliated, too hard to locate, too disordered or intoxicated, and too noncompliant. This is true for a sizable fraction of the homeless, but, as HCH has taught us, it is not true of them all. That "nothing can be done" is no longer an excuse for doing nothing, if indeed it ever was.[19]

Rephrasing the first implication in terms likely to be of greater relevance to states and local communities, money spent on the health needs of the homeless is not necessarily money wasted. The Johnson-Pew program shows that community-based primary health services can be provided and will be utilized by the homeless population. The HCH evidence (see note 10) suggests that the average project provides services to between a quarter and a third of the target population each year, an impressive rate of coverage given the inherent difficulties. The strong similarity between HCH clients and the larger homeless population also intimates that all categories of homeless people are about equally likely to avail themselves of services. Finally, with an average of about three contacts per client per year, it is also apparent that some continuity of care can be achieved.

HCH also shows that health care can be used as a starting point from which to address a range of other problems. HCH has used health care in much the same way as others have used a sandwich and a cup of coffee—as a nonthreatening and sympathetic (although admittedly expensive) way to establish contact and rapport. About a third of the quarter-million client contacts logged program wide have been with project social workers. Problems addressed in these contacts run the entire gamut: assistance with entitlements, housing, legal matters, employment, emotional crises, money management, and so on. It may also be noted that 40 percent of the clients have been given a referral elsewhere for either medical or social problems. Among the more "stable clients," those seen more than once or twice, the proportion receiving referrals is well over half.

Community-based health care for the homeless clinics, such as that found in the HCH projects, are by no means a panacea for all the problems that homeless people face. One frustration, of course, is the large percentage of clients (about half) who are seen one time and disappear; another is the rather sizable group that consistently breaks appointments, refuses treatments or referrals, and is otherwise not compliant. In fact, if success is defined in broader terms than the effective treatment of presented health problems, then genuine success stories among HCH clients would have to be counted as rare. Very few of the clients have been "made whole" by HCH; most of the homeless and destitute people who have come into contact with the system remained homeless and destitute when they left it. The successes of the program are found in the short-term alleviation of pain and suffering and the medium-term resolution of many health and some social problems faced by HCH clients, rather than in the long-term reclamation of large numbers of clients as stable, productive members of society.

Health Care Is Not Enough

Another general conclusion that needs to be stated with some urgency is that health care in the absence of adequate housing can only be crisis intervention; there is scarcely a health problem faced by homeless people that is not caused or at least strongly exacerbated by their inadequate housing situation. Thus, health care stands in relation to homelessness as aspirin stands in relation to an infection; it can lessen the severity of symptoms, but it will never cure the infection itself.

Health Care Can Be Cost Effective

The question has been raised as to whether the HCH approach is "cost effective." Program grants average about $300,000 per project per year. The average project logs about 500 patient contacts per month, or about 6,000 per year. The crude average cost per contact therefore, is, on the order of $50. All projects have outside funds that supplement their foundation grants. In some cases, this is only a token sum, and in others it comprises half or more of the total project resources.

Calculating a *cost-benefit* ratio requires two additional pieces of information—a commensurate dollar value for the derived benefit and an accounting perspective (the viewpoint from which costs and benefits are calculated). To homeless persons receiving services, the cost-benefit ratio is obviously very favorable—the costs are nil and therefore offset by any derived benefit. Whether HCH is cost beneficial to the larger society depends on many unknown factors, chiefly the social value derived from the alleviation of suffering among its homeless citizens.

Cost effectiveness involves a comparison between the value derived from alternative allocations of the same resources. To illustrate, which pays off the most—a billion dollars spent on health care for the homeless, or the same billion spent, say, on deleading buildings in central city areas? In this sense, health care for the homeless must be judged a bad investment, if only because genuine "successes" are rare. Many homeless people are, for all practical purposes, already lost as a collective social resource; a cold calculation will show that there is practically no benefit to be had in addressing their many health problems, since the return on the investment over the long run is close to zero. This same kind of calculation on solutions to hunger and overpopulation, of course, will support cannibalism on a large scale. My point is that human and political values as well as dollars and cents must be accounted for in these equations. The fact is, if as a society we choose to minister to the health needs of the homeless, it is because we are a compassionate and just people, not because we expect some commensurate economic return on the investment.

One final approach to the cost-effectiveness question, and no doubt the most favorable to a national HCH initiative, is to compare the costs of spending money in a particular way against the cost of *not* spending the money that way. To illustrate, the average dollar cost per hospital stay in the United States in 1984 was $2,995. At $50 per patient contact in the HCH program, we just break even if one in every 60 HCH patient encounters avoids the need for hospitalization. Likewise, the average cost these days for one visit to a hospital emergency room is about $1,000. If HCH intervention prevents a trip to the emergency room for one in every 20 patients, we again break even. It is by no means absurd to make exactly these comparisons. As I have already stated, in the absence of targeted programs, such as HCH, many homeless people do utilize emergency rooms as their primary health care site. In this sense, it makes sense to spend money on health care for the homeless clinics not because we derive long-term benefits but because it allows us, at least in some cases, to avoid rather formidable short-term costs.

The *McKinney Act*: Present and Future

The evident successes of the Johnson-Pew demonstration program were cited as a principal rationale for the *McKinney Act*. The act provides a wide range of services to the homeless, including primary health care, but it is only a two-year initiative. The hope is that "seed money" will get local health care for the homeless programs up and running, and that the states and local communities will assume the costs after the act expires. *McKinney Act* money for the first year has been distributed, providing some additional funds to each of the 19 HCH projects and expanding the program to 89 other localities. Second-year funding is currently in peril as the Congress and the White House struggle to bring the budget deficit under control. The current betting is that it will be eliminated or severely cut. Even if it is not, the implication for state and local government is clear. Either this year or next, the states and 108 local communities, themselves, will have to find some way to maintain the viability of health care for the homeless programs already operating in their jurisdictions.

Funds for Continuation

There is no "one best" solution to the problem of sustaining funds for health care for the homeless programs. In many states, much could be accomplished by liberalizing the eligibility criteria and payment levels for Medicaid, so that proportionally larger shares of the health care costs could be recovered through Medicaid reimbursements. Some states, such as New York and Massachusetts, have gone about as far as they can in this direction, and in these states, third-party reimbursement is a very

viable income stream that will underwrite a large share of local health care for the homeless. In other states with more stringent Medicaid eligibility criteria (such as Tennessee and Alabama, where only AFDC recipients are eligible), third-party reimbursement is not a viable sustaining mechanism unless the eligibility criteria are changed so as to make Medicaid accessible to more homeless persons.

The advantage to cities and states of liberalizing Medicaid as a means of supporting health care for the homeless is that the federal government is obliged to share part of the cost. However, Medicaid is already the second largest single item in the federal human services budget (exceeded only by the costs of Social Security and related programs). Substantial increases in the Medicaid outlay, as would be occasioned by a nationwide liberalization of eligibility criteria, would no doubt meet considerable resistance at the federal level. As a result, while part of the solution may well be found along these lines, part and perhaps most will have to be found elsewhere.

I have alluded to one bright spot in this area, the overutilization of very expensive emergency room services by the homeless in the absence of targeted programs. Some share, and perhaps a large share, of the day-to-day operation of a targeted health care for the homeless program would be offset by even small reductions in the use of emergency room care. Rephrased in perhaps overly graphic but not exaggerated terms, how many foot soaks, dressing changes, and penicillin prescriptions can be bought for the price of one emergency amputation and the ensuing hospitalization, therapy, and rehabilitation?

Many local jurisdictions, in short, might be able to fund targeted programs largely through some reallocation of their current health care expenditures. In the process, localities might find themselves actually saving money, especially if a significant share of the health care labor can be obtained through subsidized sources (for example, public health nurses or National Health Service doctors detailed to the homelessness clinic). Perhaps the operating adage is, "An ounce of prevention is worth a pound of cure." There is little doubt that the poor health of the homeless costs taxpayers a sizable sum—in emergency room overutilization, in the treatment of tuberculosis, in the need to provide welfare and other support for homeless persons too ill or physically disabled to work, and in many other ways. It may well prove more cost effective to address these needs up front, in community-funded, community-based clinics than to continue shouldering the large but rather indirect and somewhat hidden costs posed by current policies.

Keys to Success

What do the experiences of the Johnson-Pew projects suggest for *McKinney Act* grantees and other communities choosing to move in this direction? What, in short, have been the keys to success in the demonstration programs?

Dedicated Workers. In my view, the essential key has been the dedication, concern, and professionalism of the doctors, nurses, nurse practitioners, counselors, social workers, outreach workers, and case managers who have staffed the HCH projects, often at wage rates well below the going market value of their labor. Health care for the homeless is a frustrating, poorly paid, low-status enterprise that appeals mainly to dedicated, idealistic health care professionals whose principal motivation is to make the world a better place. HCH "worked" because project staff made it work, often in the face of a hostile local community and other adversities that would daunt almost anyone.

Community-Based Orientation. A second important factor has been the strong community-based health care orientation that has animated the HCH program from the start. It was perhaps an obvious decision to locate HCH sites in facilities already utilized by the homeless population—in the shelters, missions, soup kitchens, and so forth—but it was a critical decision nonetheless. The community-based health care model of the Johnson-Pew program has at least eased the sense of alienation from institutions that many homeless people feel and has resulted in a system of health care that is maximally accessible to a traditionally hard-to-reach segment of the urban poverty population.

The point is not to be taken lightly. I am often asked by staff in outpatient clinics in local public hospitals why new programs and clinics are needed, most of all in the not infrequent case where anyone who seeks health care attention in the clinic will receive it regardless of whether they can pay. The answer is that many homeless people are too confused, too sick, too disordered, or too intoxicated to find their way to such clinics, or are so profoundly suspicious of institutions that they would never even bother. Health care clinics sited in facilities used by homeless persons are at least on friendly and known turf. Consequently, they are less threatening, less judgmental, and more accessible to the homeless person.

The Johnson-Pew HCH projects can be described as 19 separate experiments to determine what works best in delivering health services to a homeless population. The data from these projects do not point to a "one best model," but there has been a definite tendency for all of the projects to evolve toward a common form, that being a central clinic with outlying sites for screening, outreach, and referral. Projects that began with this model have tended to retain it; those that began with a more decentralized model have evolved toward greater

centralization. The location of the central site is also critical. In most cities, one finds areas where the homeless tend to concentrate; the nearer to these areas the central site can be located, the better.

Outreach. A third important factor, related to the second, has been the aggressive outreach characteristic of most of the local HCH projects. Regardless of the sites where primary health care is delivered, most local projects routinely "make the rounds" (often employing formerly homeless people for the purpose) through shelters, soup kitchens, missions, and other known haunts of the homeless, offering assistance and support, attempting to engage potential clients in HCH and persuade them to come to the clinic for health care attention. Indeed, in some cases, staff-initiated (versus client-initiated) contacts account for nearly 40 percent of the total client load. In delivering health care to a homeless population, there is no substitute for an aggressive proactive stance.

As HCH becomes institutionalized across the country, one thorny issue that is certain to arise is the matter of eligibility, more specifically, who is entitled to receive benefits under the aegis of the "health care for the *homeless*" program. This is a matter to treat with caution; eligibility certification implies red tape, and red tape reduces accessibility to the target population. One distinctive feature of the Johnson-Pew programs is that virtually anyone who requests treatment receives it, no questions asked.[20] The inevitable result is that some people have received services through the program who are not literally homeless in the strictest definition of the term (see note 9). This has not been an important concern; the occasional provision of services to persons not strictly eligible is considered an acceptable trade-off for maximum accessibility among those truly in need.

The *McKinney Act* gives local communities a great deal of flexibility in designing their programs in whatever way seems most workable for them. There are, for example, no nationally standardized eligibility regulations. Homelessness is itself an ill-defined and fluid condition, a rather arbitrary and somewhat ambiguous demarcation in a continuum of housing inadequacy, with considerable movement back and forth across that line over time.[21] This being the case, while it is appropriate to focus the effort on the literally homeless, the operating model can only be health care for the homeless, the near homeless, the marginally housed, the obviously destitute, and more or less anyone else who appears to need health care that they evidently cannot afford.

Is this a workable, realistic model? Will health care clinics that adopt such a model be swamped by poor people who are not homeless, but who consume staff time and project resources and perhaps drive away the literal homeless who were the original target group? This must be admitted as a possibility, but it was not the experience of the HCH projects. Despite the "no questions asked" philosophy, not more than about one HCH client in seven would fail a strict definition of homelessness (see note 9).[22]

Coordination of Services. One especially commendable stipulation in the *McKinney Act* is that local health care for the homeless programs coordinate service delivery with other local mental health, alcoholism, and drug abuse programs. Our data suggest that as many as two-thirds of the homeless population served in the HCH program may suffer from one or more of these disorders, and perhaps a quarter suffer from two or more. There is, therefore, an evident need for coordination, communication, and resource sharing between health care programs on the one hand and mental health, alcoholism, and drug programs on the other. In the 19 Johnson-Pew projects, this sort of coordination was either present in the initial project design or developed very quickly as a critical program need.

Historically, homeless people who are both alcoholic and mentally ill have tended to fall between the cracks of the existing service delivery system, their needs not adequately addressed by alcohol treatment or mental health services alone. One consequence of improved coordination of services should be integrated treatment programs designed specifically for homeless people who are both alcohol abusive and mentally ill.

In design, a "coordinated system of service delivery" consists of little more than service nodes connected by arrows. In reality, the nodes of the system are separated by city blocks. One relatively cheap and demonstrably effective means of improving coordination of services among the nodes is to provide transportation for homeless clients as they attempt to negotiate the system. The simple need for transportation from office to office is easily overlooked, yet many homeless people are too ill, too disordered, too intoxicated, too debilitated, too poor, or too intimidated to negotiate the system on their own. The ability to provide requisite transportation is a very important component of effective case management.

An equivalent need exists for better coordination of the *health* system (including physical and mental health as well as alcohol and drug programs) with the larger *social service* system. The *McKinney Act* requires grantees to be eligible to receive payments under Medicaid and Medicare, the obvious intent being to reclaim as much of the cost as possible under the provisions of existing programs. This provision will ensure at least some degree of coordination between health care projects and local Medicaid and Social Security offices. Other social service systems of particular importance to the homeless population

include Food Stamps, General Assistance, Veteran's Administration benefits, and AFDC for families with dependent children. Because of the often fragmented nature of these and other social services, the most (and perhaps only) effective means of coordination is aggressive case management and patient advocacy.

Alcoholism and Mental Illness

Alcohol abuse is probably the single largest health problem of the homeless, especially among homeless men. The existing alcohol treatment system is not well suited to the unique needs of homeless alcoholics because even the best treatment and rehabilitation facilities imaginable can have only modest effects if, at the end of treatment, the patient returns to a life on the streets, the typical case. There is an evident need for aftercare facilities for recovering homeless alcoholics where the maintenance of sobriety is encouraged and rewarded. One promising although relatively expensive avenue is the so-called alcohol-free hotel that has been explored in several cities in California. These are usually older SROs that have been purchased and renovated (typically with a mix of private and public funds) and that are used as aftercare housing for homeless alcoholics who have finished a detoxification or alcohol rehabilitation program. Although no quantitative evaluations of these programs have been conducted, the chances for success are obviously brighter if one can provide an environment where sobriety is valued than if the patient is simply released to the streets.

Many HCH clients have encountered long delays while awaiting a detoxification or rehabilitation placement. Regardless of aftercare provisions, the sheer number of alcohol treatment slots available to the homeless population needs to be increased. It is difficult enough to persuade many homeless alcoholics to accept treatment. Delays of days, weeks, or months in finding an open treatment slot are therefore a particular frustration. In the interim, the motivation to accept treatment may and often does abate.

It needs to be added that many homeless alcohol and drug abusers consistently refuse treatment despite the frequency and urgency with which it is offered. For this group, expanded treatment facilities and aftercare provisions mean nothing, and indeed, there is reason to doubt whether much if anything can be done in their behalf. There are some among the homeless, especially among the alcohol abusers, whose lives will not be improved despite the best efforts of their care providers. That such a group exists is a fact of life that must simply be accepted, but it is no excuse for diminished efforts in behalf of other homeless people who can be helped.

Next to alcohol abuse, mental illness is the second leading health problem, and it is particularly widespread among homeless women. The existence of large numbers of chronically mentally ill persons among the homeless has been cited as proof that deinstitutionalization has failed as a social policy. Whether or not it has failed in general, it has clearly failed for some. What to do with or about the deinstitutionalized (or never institutionalized) mentally ill who have not been successfully reintegrated with their families and communities is an exceedingly difficult and contentious issue that raises many legal and ethical questions.

Many who have written on this issue are clearly motivated by an urge to avoid institutionalization of the mentally ill at any cost, particularly involuntary commitment to treatment. However, "no institutions" is not the only alternative to large, impersonal, and degrading institutions. Smaller, more humane, and more effective institutions remain as another option. In fact, deinstitutionalization was itself premised on the vastly increased availability of community mental health facilities—mental health centers, crisis intervention programs, after-care and halfway houses, and the like. The problem is that these smaller, community-based institutions were never created in sufficient numbers. Our distaste for the concept of an institution, and the associated imagery of the human warehouse, should not blind us to the evident need among many mentally ill homeless for a 24-hour-a-day total care environment, no matter what it is called.

Conclusions

Health is an important part of the homelessness problem and provides a challenge to the entire health care system: federal, state, and local. The larger problem and the larger challenge, however, lie in what has been described as the "deteriorating access [to health care] among the poor, minorities, and the uninsured."[23] There are probably fewer than a million homeless people in the United States on any given day. In contrast, Howard Freeman and his associates report that, in 1986, some 6 percent of the population, amounting to 13.5 million persons, "failed to obtain needed medical care for economic reasons. . . . The majority of Americans experiencing these difficulties were poor, uninsured, or minorities." Better health care for the homeless is, at best, only a first step.

The Johnson-Pew program has demonstrated that health care can be provided to the urban homeless. The program has also given us some important clues about how to do it and about the problems, costs, and gratifications that will be encountered. HCH, it might be said, has invented the wheel; the challenge to states and local communities is to get that wheel rolling in their own jurisdictions with little or no direct, long-term support from the federal government.

In general, state and local budgets are as tight as, or tighter than, the federal budget. Homeless people and their advocates, moreover, have very little political clout. All states and communities face numerous threats to the quality of life; homelessness is only one of them, and probably not the most important. Where, then, is the mandate to address the needs of the homeless at any governmental level?

The mandate comes from the basic decency and generosity of the American people themselves. A recent survey by the Roper Organization asked a sample of the U.S. population what problems we should be spending more money on.[24] "Caring for the homeless" was the top priority item, favored by 68 percent. In contrast, foreign aid was mentioned by only 5 percent, and "military, armaments, and defense" by only 17 percent. It seems the people have spoken. Let us hope they are being heard.[25]

Endnotes

[1] This paper is adapted from Chapter 10 in James Wright and Eleanor Weber, *Homelessness and Health* (New York: McGraw Hill, 1987).

[2] See, for example, P. W. Brickner, L. K. Scharer, B. Conanon, A. Elvy, and M. Savarese, eds., *Health Care of Homeless People* (New York: Springer Publishing, 1985); J.D. Wright, et al., "Homelessness and Health: The Effects of Life Style on Physical Well Being among Homeless People in New York City," in M. Lewis and J. Miller, eds., *Research in Social Problems and Public Policy*, Volume IV (Greenwich, CT: JAI Press, 1987), pp. 41-72.

[3] On the matter of extreme poverty among the homeless, see P. Rossi, J. Wright, G. Fisher, and G. Willis, "The Urban Homeless: Estimating Composition and Size," Science 235 (March 13, 1987): 1336-1341. Those data show that the average homeless person survives on something between 25 percent and 40 percent of the *poverty-level* income.

[4] Healthcare for the Homeless Coalition of Greater St. Louis, *Program Description*, 1986, mimeographed. Also relevant is A. Elvy, "Access to Care," Chapter 16 (pp. 223-231) in Brickner, *Health Care of Homeless People*.

[5] For a description of the Johnson-Pew program configuration and philosophy, see J. D. Wright, "The National Health Care for the Homeless Program," Chapter 9 (pp. 150-169) in Bingham, Green and White, eds., *The Homeless in Contemporary Society* (Beverly Hills, CA: Sage Publications).

The 19 participating cities are: Albuquerque, Baltimore, Birmingham, Boston, Chicago, Cleveland, Denver, Detroit, Los Angeles, Milwaukee, Nashville, Newark, New York City, Philadelphia, Phoenix, San Antonio, San Francisco, Seattle, and Washington, DC.

[6] See P. Rossi, "The 'New' Homeless and the 'Old.' " The Jenson Lectures, Duke University, October 1987.

[7] Among many pertinent studies demonstrating these points, see in particular J. D. Wright and J. Lam, "Homelessness and the Low-Income Housing Supply," *Social Policy* 17 (Spring 1987): 48-53; E. Bassuk, "The Homeless Problem," *Scientific American* 251 (1984): 40-45; E. Baxter and K. Hopper, "The New Mendicancy: Homeless in New York City," *American Journal of Orthopsychiatry* 52 (1982): 393-408; J. Erickson and C. Wilhelm, eds., *Housing the Homeless* (New Brunswick, NJ: Rutgers University, Center for Urban Policy Research, 1986); M. Hope and J. Young, *The Faces of Homelessness* (Lexington, MA: D.C. Heath and Company, 1986); and F. S. Redburn and T. F. Buss, *Responding to America's Homeless* (New York: Praeger Publishers, 1986).

[8] Much additional data on the HCH clients and specific (in some cases, city-by-city) comparisons to the larger homeless population are reported in Wright and Weber, *Homelessness and Health*.

[9] There is no universally agreed upon definition of homelessness in the first place, and certainly none that is employed throughout all 19 projects for screening purposes. The HCH projects do all they can to minimize "red tape" and thereby maximize ease of access for the target population. The result is that at least some clients receive services even though they would not satisfy a strict definition of homelessness.

Results from a Case Assessment and Review Questionnaire filled out for a sample of clients seen during the first year of the program suggest, incidentally, that about 85 percent of them *would* satisfy a technical definition of homelessness, however exclusive; the remaining 15 percent lie somewhere near the boundary between marginally housed and literally homeless.

[10] Selection bias appears to be minimal for the following reasons: First, the national program is animated by a very strong community-based health care orientation. The demonstration projects are not sited in conventional health care settings, but are located out in the community in facilities utilized by the target population. Access to HCH services is by design not a difficult process.

Second, most projects have very aggressive outreach components that would tend to reduce self-selection. Several projects employ former homeless persons as outreach workers who scour the known haunts of the homeless attempting to draw clients into the system. One measure of the success of outreach is that, in the cities where we can undertake the appropriate calculations, the client load in the first year of operation appears to have amounted to between a quarter and a third of the total homeless population of the city (Wright and Weber, *Homelessness and Health*, Chapter 2).

Finally, as I have already suggested, it is possible in some cities to compare HCH clients to the homeless population of the city in general. In general, these comparisons are very close wherever comparison is possible, especially in regard to gross demographic characteristics such as sex ratio, age distribution, or ethnic mix.

Given the emphasis on health services, it might at least be thought that HCH clients are physically sicker than homeless people in general. It is true that the client base is a *clinical* population; on the other hand, the general health status of homeless persons is so poor that clients receiving HCH services may well be no sicker on average than homeless persons in general. Health screenings of shelter populations, for example, routinely find 40 to 60 percent with health problems in need of medical attention.

[11] The point of the comparison is to stress that a minority of the HCH clients are chronically homeless precisely because only a minority of the homeless in general are chronically homeless, not because the chronically homeless are underserved in HCH facilities. All recent studies that have inquired into the matter have shown relatively small numbers of chronically homeless persons and

relatively large numbers of short-term, transitory, or episodically homeless.

[12]Evidence on the following points is found in Wright and Weber, *Homelessness and Health*, Chapters 5 through 7.

[13]The summary figures given for rates of alcohol abuse and mental illness are derived from a relatively complicated set of procedures that were developed to correct for the problem of underdiagnosis. In brief:

Problems such as alcoholism and mental illness tend, for various reasons, to be underdiagnosed in the early stages of a client's clinical history. This is true at all levels of medical practice and is not unique to the homeless. Still, the problem is particularly vexing in this case because of the large number of clients (about half) who have been seen only once. It is easy enough to ask about the *observed* rate of alcohol abuse among clients seen only once, but how does that compare with the true rate?

To answer this question, we sorted out all clients who had been seen at least five times and who were known to be alcohol abusers. (Identical procedures were also followed for drug abuse and mental illness.) We then reconstructed each client's visit history, noting the exact contact at which the disorder was first recorded. Thus, among all known alcoholics seen at least five times, only 43 percent were diagnosed as alcoholic *on the first visit*. Further, among all persons seen just one time, 17 percent are noted as alcohol abusive. Since only 43 percent of the alcoholics appear to be diagnosed at the first visit, and since 17 percent of those seen just once were diagnosed as alcoholic, it follows that 17 percent is itself only 43 percent of the true alcoholism rate. From this reasoning, it further follows that the true rate is 17/.43 = 39.5 percent. The same calculations can be done for those seen two times, three times, four times, and five or more times; the average estimate over these five "contact groups" is 38 percent with an alcohol problem (and also: 34 percent who are mentally ill, 13 percent who abuse drugs other than alcohol). See *Homelessness and Health*, Chapters 5 and 6, for details.

[14]The literature on alcohol and mental health problems of the homeless is immense. One useful overview is to be found in *Alcohol, Drug Abuse, and Mental Health Problems of the Homeless: Proceedings of a Roundtable* (Washington, DC: U. S. Department of Health and Human Services, Public Health Service, 1983).

Pertinent recent studies of the alcohol issue include: J. Knight, *Alcohol Abuse among the Homeless*, unpublished doctoral dissertation, University of Massachusetts, Amherst, 1987; P. Koegel and A. Burnam, "Traditional and Non-Traditional Homeless Alcoholics," *Alcohol Health and Research World* 11 (Spring 1987): 28-34; R. Morgan, et al., "Alcoholism and the Homeless," Chapter 10 (pp. 131-150) in Brickner, *Health Care of Homeless People*; V. Mulken and R. Spence, "Alcohol Abuse/Alcoholism among Homeless Persons: A Review of the Literature." Final Report, National Institute of Alcohol Abuse and Alcoholism (November, 1984); J. D. Wright and J. Knight, *Alcohol Abuse in the National "Health Care for the Homeless" Client Population* (Washington, DC: National Institute of Alcohol Abuse and Alcoholism, 1987).

And on the topic of mental health, the following are worth attention: L. Bachrach, "The Homeless Mentally Ill and Mental Health Services: An Analytical Review of the Literature." Report prepared for the Alcohol, Drug Abuse and Mental Health Administration, U.S. Department of Health and Human Services (April, 1984); L. Bachrach, "Interpreting Research on the Homeless Mentally Ill, Some Caveats," *Hospital and Community Psychiatry* 35 (1984): 914-916; N. Cohen, J. Putnam, and A. Sullivan, "The Mentally Ill Homeless: Isolation and Adaptation," *Hospital and Community Psychiatry* 35 (1984): 922-924; H. R. Lamb, "Deinstitutionalization and the Homeless Mentally Ill," *Hospital and Community Psychiatry* 35 (1984): 899-907; F. R. Lipton, A. Sabatini and S. Katz, "Down and Out in the City: The Homeless Mentally Ill," *Hospital and Community Psychiatry* 34 (1983): 817-821; S. P. Segal, J. Baumohl, and E. Johnson, "Falling through the Cracks: Mental Disorders and Social Margin in a Young Vagrant Population," *Social Problems* 24 (1977): 387-400; D. A. Snow, et al., "The Myth of Pervasive Mental Illness among the Homeless," *Social Problems* 33 (June 1986): 407-423.

[15]On the problem of tuberculosis among the homeless, see also J. McAdam, et al., "Tuberculosis in the SRO/Homeless Population," Chapter 12 (pp. 155-175) in Brickner, *Health Care of Homeless People*; Centers for Disease Control, "Drug-resistant Tuberculosis among the Homeless—Boston," *Morbidity and Mortality Weekly Report* 34:28 (July 19, 1985).

The estimated rate of tuberculosis in the HCH data is about 500 cases per 100,000 homeless people. The national infection rate is 9 cases per 100,000; the national rate for urban dwellers only is 19 per 100,000; the rate among urban ambulatory patients is 66 per 100,000. Moreover, only about a tenth of all HCH clients have been documentably screened for TB, so the true rate of infection could actually be much higher than the estimated 500/100,000.

[16]See *Homelessness and Health*, Chapter 9. We explored three possible reasons for why as many as 80 percent of the clients get benefits in some cities and only 20 percent in others: (1) some states have more lenient eligibility criteria; (2) some projects see more clients who are easier to enroll in benefit programs (meaning, basically, more women, children, and elderly); and (3) some projects invest more effort in getting clients enrolled in benefits. Across the 19 projects, these three factors explain 78 percent of the variation in the percentage receiving any benefits: 69 percent of the variance is explained by the first factor listed above, 3 percent by the second factor, and 6 percent by the third. Thus, project-to-project differences in the percentage receiving benefits is determined overwhelmingly by state-level "leniency" factors.

[17]See the GAO report, *Homelessness: A Complex Problem and the Federal Response* (Washington, DC: US Government Accounting Office, 1985), specifically pp. 38-39.

[18]Judging a client's potential eligibility for Medicaid or Medicare is a complicated process, owing mainly to the large state-by-state differences in Medicaid eligibility rules. Our estimate is derived as follows:

First, we receive data from both health care providers and project social workers. Many of the problems and treatments dealt with by both groups involve social as opposed to strictly medical problems, and mentions of "problems related to entitlements" are indeed quite common. We take great pains during coding to assure that any mention of entitlements and benefits appearing on the Contact Form is coded and entered into a client's file.

Based on these data, we can then sort out clients (1) who are not known to be enrolled in a specific entitlement program and (2) for whom there is no evidence from the narratives that the project is trying to get them enrolled. We treat those as "ineligible" for that specific program, on

the assumption that if there were any reason to think a client *might* be enrollable, then there would be some evidence in the narratives of efforts toward this end. (Recall that enrolling clients in programs for which they are eligible is a leading and explicit program goal.)

Our final estimates exclude clients seen only once and also clients for whom we have no information about benefit statuses. Among those who remain, 76 percent are not enrolled in Medicaid and no one is trying to enroll them. Thus, about 24 percent are either enrolled or potentially enrollable. For Medicare, the corresponding figure is 94%.

[19]The "myth of the untreatable homeless" derives at least in part from the stereotype that most of the homeless are chronically alcoholic or chronically mentally ill. As I have already stated, these remain important health issues for the homeless, but the fact is that a majority of some 60 percent are not alcohol abusers and an even larger majority of two-thirds are not mentally ill.

[20]In a few projects, once the case load approached the resource limitations, it was in fact necessary to do some screening of potential clients. Even in these cases, however, clients determined not to be appropriate for HCH would at least receive some attention to their presenting health problem and a referral to a more suitable program or care provider. It is also true that when the need for some screening arose, it was at a point in the evolution of the program where the project had already gained the trust of its homeless clientele.

[21]Researchers from the University of Wisconsin have recently tracked a sample of 339 homeless men and women over a six-month period. Over the six months, fully three-quarters of the sample had found places to live at least once. Among that three-quarters, the majority then became homeless one more time during the period, and of those who had again become homeless, 55% had found yet another place to live. Tracking the modal person through the data, the most common pattern is to be homeless at the start of the period, to then find a place to live, to then become homeless again, and to then find another place to live—two episodes of homelessness and two more or less stable housing situations all in a six-month period. See "Tracking the Homeless," *Focus* 10 (Winter 1987-88): 20-24.

[22]The reason that the HCH projects did not become "magnets" attracting larger numbers of non-homeless people with the possibility of free health care is probably location. Most HCH sites are located in facilities set up specifically for homeless people.

[23]H. Freeman, et al., "Americans Report on Their Access to Health Care," *Health Affairs* 6 (Spring 1987): 6-18.

[24]The poll results are reported in *Newsweek* magazine for September 21, 1987, p. 7.

[25]Research reported in this paper is supported by a grant from the Robert Wood Johnson Foundation. Conclusions and interpretations are my sole responsibility and do not necessarily reflect the views of the foundation or its officers.

Appendices

The Conference

ASSISTING THE HOMELESS:
STATE AND LOCAL RESPONSES IN AN ERA OF RETRENCHMENT

March 10-11, 1988

A Policy Conference
Sponsored by the
U.S. Advisory Commission on Intergovernmental Relations

Hyatt Regency Hotel
400 New Jersey Ave., NW
Washington, DC 20001

Homelessness is a growing problem in the United States. The complex, multifaceted nature of the problem makes it difficult to formulate effective solutions. Since the causes of homelessness are numerous and the homeless population is heterogeneous, policy prescriptions to aid the homeless must be varied. In light of the federal government's budget problems, declining federal aid to state and local governments, and court decisions regarding individual rights, how can state and local governments develop more effective and coordinated responses to homelessness?

The principal purpose of the conference is to identify crucial intergovernmental issues affecting policy responses to homelessness and, thereby, to strengthen intergovernmental cooperation in ways that can improve state and local policy responses.

The conference will bring together experts from various levels of government, private organizations and academic institutions. Research papers will be presented for discussion and criticism. The driving question for the conference will be: How have, can, and should state and local governments respond to homelessness? Additional questions involve the role of the federal government and private profit and nonprofit organizations.

Some of the questions of particular interest are:

- What kinds of innovative policies are being undertaken by public and private organizations? How effective are they? How can we determine which kinds of programs would be best for particular communities? What public-private mix should we look for in dealing with homelessness? What kinds of public-private and/or local/state partnerships could be developed to help solve the problems of the homeless? What role have federal grant and program policies played in aggravating and/or alleviating homelessness?

- What are the principal causes of homelessness? How has the makeup of the homeless population changed over the past ten years? Has the feminization of poverty contributed to homelessness?

- How have policies regarding such matters as deinstitutionalization, low-income housing, and gentrification contributed to the problem of homelessness?

- What kinds of programs would be most beneficial to homeless families and the chronically mentally ill homeless? What kinds of institutional barriers do different homeless groups face in terms of getting housing, employment, health care, and/or entitlement funds?

- How have changes in the supply of low-income housing affected the problem of the homeless? What kinds of programs should, can, and do state and local governments undertake to respond to this problem?

- Is homelessness likely to be a short-term or long-term phenomenon? Are the policies designed to alleviate the problems more long-term or short-term?

AGENDA

March 10, 1988

9:00 am **Welcome and Opening Remarks**

Opening Remarks
Cassandra Moore
Executive Director
Interagency Council on the Homeless
Washington, DC

"Homeless Policy:
Expansion During Retrenchment"
Donna Kirchheimer
Associate Professor of Political Science
Lehman College, Bronx, New York

Discussant:
Kay Young McChesney
Department of Sociology
Indiana University of Pennsylvania
Indiana Pennsylvania

10:15 **Low Income Housing and the Homeless**

"The Low-Income Housing Crisis and its Impact on Homelessness"
Cushing N. Dolbeare
Consultant on Housing and Public Policy
Washington, DC

Discussant:
Anthony Downs
The Brookings Institution
Washington, DC

"From Refuse to Refuge to Community Planning and Design: Rethinking Housing with the Homeless in Mind"
Jacqueline Leavitt
Associate Professor
Graduate School of Architecture and Urban Planning
University of California at Los Angeles

Discussant:
Anna Kondratas
U.S. Department of Agriculture
Washington, DC

12:15 pm **Lunch**

1:30 **Deinstitutionalization and Mental Health**

"The Homeless Mentally Ill"
H. Richard Lamb, MD
Professor of Psychiatry
University of Southern California School of Medicine

Discussant:
Pamela J. Fisher
Department of Psychiatric and Behavioral Sciences
Johns Hopkins University
Baltimore, Maryland

"Coordinating Interagency Policies and Services to Deliver Mental Health Services to Homeless People"
Carol Bower Johnson
Director of Homeless Services
Massachusetts Department of Mental Health

Discussant:
Jim Havel
National Alliance for the Mentally Ill
Arlington, Virginia

"Reaching Mentally Ill Homeless Persons: When Less is More"
Mark Rosnow
Director of Research
Planning Council for Health and Human Services
Milwaukee, Wisconsin

Discussant:
Debra Rog
Program for the Homeless Mentally Ill
National Institute of Mental Health
Rockville, Maryland

"Health Care for the Homeless: The Challenge to States and Local Communities"
James Wright
Acting Director
Social and Demographic Research Institute
University of Massachusetts at Amherst

Discussant:
Harold Dame
Bureau of Health Care Delivery and Assistance
U.S. Department of Health and Human Services
Rockville, Maryland

March 11, 1988

8:00 am **Opening Remarks**

8:15-9:45 **The State and Local Experience**

"Translating Research into Public Policy: Ohio's Coordinated Response to the Problems of Homelessness"
Dee Roth
Chief
Office of Program Evaluation and Research
Ohio Department of Mental Health

Discussant:
Norweeta Milburn
Institute for Urban Affairs and Research

Howard University
Washington, DC

"Assisting the Homeless in an Era of
Federal Retrenchment:
The Massachusetts Experience"
Nancy Kaufman
Assistant Secretary
Executive Office of Human Services
Boston, Massachusetts

Discussant:
Robert Huebner
Program Evaluation and Methodology
U.S. General Accounting Office
Washington, DC

"Homelessness and the New Federalism:
The Westchester Experience"
The Honorable ***Andrew P. O'Rourke***
County Executive
Westchester County, NY

Discussant:
Laura Waxman
United States Conference of Mayors
Washington, DC

10:00-11:30 Policy Alternatives for the Federal, State and Local Governments

"Model State Legislation to
Assist the Homeless"
Maria Foscarinis
Washington Counsel
National Coalition for the Homeless

Discussant:
Charles W. Washington
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Business Administration
George Washington University
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"Hope for the Homeless:
Local and State Response"
Kenneth J. Beirne
Assistant Secretary for
Policy Development and Research
U.S. Department of Housing and
Urban Development
Washington, DC

Discussant:
David A. Bley
Budget Associate to
U.S. Representative Mike Lowry
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Concluding Remarks:
William G. Colman
Former Executive Director of the ACIR
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